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A discourse analysis of the nature of shared decision-making in general practice consultations

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Contents

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Declaration

I ..... declare that I am the author of this thesis. Unless otherwise stated, all references have been consulted by me. The work of which the thesis is a record has been done by me and it has not been previously accepted for a higher degree.

I ..... confirm that the conditions of the relevant Ordinance and Regulations have been fulfilled.

Abstract

This study explores the nature of shared decision-making (SDM) in general practice consultations. It has been claimed that patient involvement in their own health and healthcare improves concordance, patient satisfaction and outcomes. Although this approach to treatment decision-making is widely advocated the process of sharing decisions has, to date, been little understood. Cognitivist or intra-psychic assumptions about decision-making have underpinned the traditional methods of investigation into the doctor-patient consultation and as a result, interactional dynamics have not taken centre stage. Participants' motivations and emotions have been 'read' as enduring entities rather than as discursive constructions attending to interactional matters. As a consequence most of the work into the medical encounter has tended to be one-sided and addresses only one participant at a time. Thus, one half of the interaction may be neglected. Therefore, only a partial picture of the nature of interaction is provided. In summary therefore, traditional approaches have not considered the medical encounter as a process of joint-production and decision-making as an emergent property of the interaction. In contrast this study adopts a discourse analytic approach that allows for a fine-grained examination of what might be described as the minutiae of the interactional flow and trajectory of consultation. An examination of the content and form of the consultation-as-interaction has been undertaken in order to identify and describe a variety of discursive devices and resources that participants deploy to accomplish particular activities. As a result, the analysis provides an insight into the actual processes of the SDM consultation and *how* treatment decisions are arrived at. The primary data source was audio-recorded consultations having been initially identified from a questionnaire survey and patient interviews. Three analytic themes that are key aspects of the SDM consultation are examined. These are, the generation of patient involvement using first-person pronouns; the construction of direct, successful and unsuccessful requests from patients; the rhetorical construction of risk and evidence, with attention to the locating of agency. The analytic conclusions illuminate the complexities arising within the medical encounter and highlight problem aspects which impact on the theoretical and philosophical foundations SDM. Notably, SDM does not happen with the ease implied by current models and may work to maintain a biomedical GP as 'expert' approach rather one in which the patient is truly involved in partnership. In short, new information is available on the consultation process. This information has implications for health care practice and communication skills training and existing models of SDM may need to be re-evaluated.

CHAPTER ONE

Introduction

This thesis focuses on shared decision-making in general practice consultations. It examines and describes the nature of this particular form of treatment decision-making from the conversational activities of both the doctor and the patient and views the consultation as a process of joint-production. This chapter begins with a brief introduction to the background to the study before describing the theoretical orientation taken and the aims of the study. Following this a brief outline of the methods used is presented. The chapter concludes with a description of the thesis structure.

1.1 Background to study

The traditional model of medical decision-making, in which doctors make decisions on behalf of their patients, has increasingly come to be seen as outdated (Stevenson *et al*, 2000) and represents a challenge to the established biomedical model. Moreover, alongside a recognition that society has evolved with a highly developed sense of the person as a self or agent in the world, the role of the patient in the consultation has been emphasised and been supported in principle with the adoption of patient-centred strategies such as, '*concordant*' prescribing [1] (Blenkinsopp *et al*, 1995) and shared decision-making (e.g. Bradley *et al*, 2000). These sociological changes in views on

[1] 'concordance' is where the patient and prescriber have discussed in detail the value of adherence to treatments

health care and doctor-patient interaction can be seen to have followed similar changes in education with for example, 'child-centred' learning in schools and 'student-centred' approaches in higher education.

It is accepted that there are three main approaches to treatment decision-making in medical consultations (Charles *et al*, 1999). The traditional doctor-centred approach is where the clinician decides alone (and with the patient's best interests paramount) on the appropriate treatment or care to prescribe. The opposite of this approach is when the doctor helps to provide the patient with appropriate information on the various treatment options available but steps back to allow the patient to decide for her/him self. Shared treatment decisions are said to occupy a middle ground between these first two approaches. Here, the doctor and patient will share information and together will negotiate the treatment decision that is acceptable to both participants. Shared decision-making in health care is regarded as important by health professionals and policy makers because research evidence suggests this approach can lead to greater patient satisfaction, improved commitment to therapy, and improved outcomes (Barry *et al*, 1995; Entwistle and O'Donnell, 2001).

1.2 Research problem

Shared decision-making is, however, still in its infancy, and techniques for achieving it continue to be developed and refined (Elwyn *et al*, 1999). Although widely advocated, there has been little research that has looked at attempts to explicate and understand the subtleties and complexities involved in sharing decisions and thus, they remain little understood. In part, this has been due to limitations with the traditional methods employed to study this form of the medical encounter. These methods include both

quantitative and qualitative approaches. Furthermore, it is not yet clear how to describe this process (Charles *et al*, 1999) and attempts to investigate the various aspects of shared decision-making (e.g. patient involvement) are hampered because there are difficulties in constructing reliable tools to measure or evaluate it (Mead and Bower 2000).

1.3 Justification for research

Models of shared decision-making have tended to be theoretically, not empirically derived and thus, are problem and do not accord enough with the patients perspective. There is still a considerable need to define and refine the process (Entwistle *et al*, 1998; Coulter *et al*, 1999; Towle and Godolphin, 1999). Murphy and Mattson (1992) have reported that methodologies (both research and practice methodologies) typically reflect the philosophical orientation of General Practice. For example, in terms of practice and communications skills training to student practitioners and with little attention to the contributions made by the patients in the communication patterns and the unfolding of the consultation. Previous studies on shared decision-making have two major limitations. First, they assume patients want greater involvement in decisions about their health care. Second, these studies have used questionnaires constructed around researcher-determined variables to assess patients' views of the decision-making process. Consequently, they have failed to take into consideration patients' own understandings of what might constitute important factors in shared decision-making. It is likely, therefore, that there are aspects of shared decision-making which patients consider important and are not taken into account by these studies. As a result, previous studies provide only a limited understanding of how shared decision-making is or is not accomplished in the consultation setting. Thus, there is a need to investigate the nature

of shared decision-making in order that professionals do not develop strategies that may be based on untested assumptions.

1.4 Methodology

To understand how shared decision-making is achieved in practice it is necessary to study individual cases in depth. The aim of this study is to investigate the nature of how shared decisions are accomplished as a process of joint-production i.e. in collaboration with clinicians and patients within the clinical encounter. The particular focus is on identifying how participants engage in the decision-making process.

The study uses discourse analysis, a theoretical framework and method for analysing spoken and written language (e.g. Potter and Wetherell, 1987, Potter, 1996). This methodological approach has been described as ideally suited to the study of medical situated encounters (Elwyn and Glyn, 1999). As there are a variety of discourse analytic approaches available, the particular discourse analytic approach deemed most appropriate for this study comes from the field of discursive psychology. This discipline holds the view that language use or 'talk' is varied and contradictory and that it is used to perform particular functions. Thus talk is 'action-orientated' (Edwards and Potter, 1992). Using Edwards and Potter Discursive Action Model (DAM) it has been possible to identify and describe some of the detailed discursive strategies and activities deployed by participants within the consultation to achieve clinical decisions.

Thus, the analytic approach has enabled an examination of how interactions unfold in the shared decision-making setting. In other words, this study has taken a fine-grained

look at *how* shared decision-making is constituted and constructed within the *'everyday'* talk at the *localised* and *situated* level of the medical consultation. The decision-making setting had to be examined at this level and in the terms set out above in order to obtain information that would influence consultation skills training. The next section outlines briefly the methods used to collect the data.

1.5 Methods

This thesis argues that for the broad aims of the research, both qualitative and quantitative methods are valuable, practical and appropriate. This work attempts to conduct a trans-disciplinary study of the medical encounter, taking into consideration both the influences from social psychology and academic general practice.

The data were collected through audio-recording consultations between patients and their GPs. A questionnaire and interviews were used as filters to identify best practice examples of shared decision consultations from the patients' perspective. Thirty consultations were ultimately selected and transcribed. To fulfil the theoretical aims for a fine-grained examination (such as a focus on repertoires and the use of pronouns etc) and for practical reasons, only extracts from the consultations were ultimately selected for discourse analysis.

1.6 Thesis structure

Chapter 2 presents a brief exploration and overview of the bodies of literature that have influenced the study of the doctor–patient relationship. This review briefly charts the historic developments that led to paradigmatic shifts in the views held and the clinical

approaches taken to the medical encounter. It describes the traditional doctor-centred and 'bio-medical' models through to 'biopsychosocial' and 'patient-centred' approaches such as shared decision-making. The section moves on to provide a description and examination of the shared approach to treatment decision-making in general practice. After identifying some of the limitations and gaps in the existing knowledge, the chapter concludes by proposing that an alternative way to examine the SDM encounter is required.

Chapter 3 introduces the methodological approach taken by this study. Here it is proposed that, by re-conceptualising the consultation as a discursive event, new knowledge can be formed that can influence training programmes in communication skills for health practitioners. This section locates the method of analysis within a social constructivist perspective. It details the theoretical background and the development of the particular form of discourse analysis used in this study. This chapter concludes with the introduction of the research questions. Next, Chapter 4 charts the data collection procedure and describes the secondary methods used for this. Finally, the process of analysis is described in depth.

1.7 Key Findings

The next section encompasses three chapters of analysis (Chapters 5-7). Three analytic themes identifying some of the key features involved in the shared decision-making style of consulting behaviour are explored. The first of these examines the generation of 'partnership talk' through the deployment of first-person pronoun use during the treatment discussion stages. This chapter highlights variability and ambiguity with the rhetorical orientation of first-person pronoun use. The analytic conclusions suggest that

pronoun use such as 'we' or 'us' can be seen to challenge the shared model of decision-making by helping to mask imputations of power and control. Analysis showed that first-person pronoun use worked to invite consensus and enabled the speaker to take control of the conversational space and trajectory. It was found that the speaker using 'we' or 'us' was almost always the doctor. Conversely, it was also found that on occasions where the doctor was less inclined to use 'we' or 'us', there appeared more patient involvement in decision negotiation.

The second analytic chapter continues to focus on patient involvement through the examination of patients' direct request making. This theme was identified as relevant because making requests directly is regarded as an unusual event in more doctor-centred consultations. Exploring this event has provided a useful insight into how requests can be constructed as successful or unsuccessful. The analytic conclusions suggest that saying no is difficult to accomplish for both participants.

The final analytic chapter details the construction of risk and evidence and the impact that these formulations had upon the encounter. Risk and evidence talk was found to perform a variety of actions, e.g. invite consensus from patients for particular courses of action and at times served to locate the patient as the agent responsible for managing risk. It was also noted that participants appear to orient more to the immediate interactional concerns than to the medical matters under discussion. The downplaying of risk raises interesting issues over the ways in which potential areas of concern and even liability are avoided. The construction of risk and evidence was seen to help retain the biomedical model as the dominant ideology.

The concluding chapter (Chapter 8) presents a discussion of the main analytic findings. This chapter suggests that the practice of sharing decisions is complex and does not occur with the ease implied by the current models. The implications of the findings for models of shared decision-making, training programmes in consultation skills, concordance and future research trends are discussed as a means of taking forward the findings from this study. The limitations of the study are discussed in terms of a critique of discourse analysis and the potential issues involved in putting into practice DA findings.

CHAPTER TWO

Dialogue and Decisions in General Practice Consultations: A Literature Review

2.1 Introduction

This chapter begins with an account of the literature search strategy before providing a brief overview of the traditional approach to the investigation of the doctor-patient encounter in general terms before moving on to discuss in more detail the theoretical concept of shared decision-making. It concludes by calling for a different way to conceptualise and investigate the shared treatment decision encounter in order that new knowledge can be sought and suggests why this should be regarded as an important contribution.

2.2 Structure of literature search

2.2.1 Search strategy

The principal aim of the search was to identify studies that reported on aspects of shared decision-making in medical consultations in primary care. The Web of Science citation databases were searched systematically from 1995. The initial limits were set to include all document types. The keywords and terms included, for example, 'shared decision-making' and 'med*' and 'consultations', 'patient-centred' and 'not' 'clinical governance', 'not' 'schools'. Besides electronic searching a number of journals were

hand searched. These have included the Journal of Family Practice, Journal of Health Service Research, Qualitative Health Research and some social science journals, e.g. Text, Discourse and Society and Social Science and Medicine. Personal correspondence with key researchers in the field of SDM has also been used to inform direction of study (e.g. Edwards and Elwyn, 2000), as has material from conferences. The subject area is not well indexed however and after preliminary searching it soon became apparent that there were a substantial number of interchangeable terms in use for SDM. For example, patient-centredness, patient involvement, physician-patient relationship, patient satisfaction, mutuality and concordance are only a few of the terms used alongside SDM. Thus, the simplest of searches around the topic of decision-making produced a large and unfocused volume of papers (725 references in total). In order to refine the search a decision about which studies to include was required.

2.2.2 Initial appraisal of identified articles

Initially, the abstracts of articles identified were read to assess relevance. The inclusion criteria were based on the investigation or assessment of any aspect of shared decision–making. Those identified as appropriate were grouped into categories relating to, for example, the 'process' of SDM (accomplishment of decision-making), evaluation of SDM (i.e. level of patient involvement) or models of SDM (skills or competences required). Both qualitative and quantitative studies were included in the review.

2.2.3 Criteria for considering studies

The two main criteria for inclusion were, first, that studies related to consultations in general practice and second, that the studies reported on patient-centred care or shared decision-making. Studies relating to e.g. shared governance, shared leadership, team decision-making, decision-making in medical career choice, decision-making in policy setting and those relating to nursing behaviours were excluded. Records of search terms were kept in order to help with cross-referencing and the details of articles retrieved have been stored in Reference Manager (1998).

2.2.4 Results

The literature reviewed was broadly classified into four main areas of investigation into SDM: the study of how health professionals involve patients in decision-making (van Thiel *et al*, 1992); the identification and assessment of the competences required for shared decision-making (e.g. Marvel et al, 1994; Towle and Godolphin, 1999); evaluation of participant involvement and quality of SDM (e.g. Makoul *et al*, 1995; Coulter *et al*, 1999); and finally, the study of the interaction within the consultation (e.g. Barry *et al*, 2000).

2.3 Structure of the literature review

The literature on doctor-patient communication has produced a copious array of empirical findings from various lines of inquiry and investigation. The results of the search identified two general bodies of literature relevant to this thesis. The first comes

from the social sciences and the second is from the field of academic general practice. The first section of the review will identify the social scientific perspective and report briefly on the psychosocial views on medicine before moving on to an overview of the traditional approach to the consultation and the doctor-patient interaction.

The second part of this chapter examines the literature on the academic general practice approach to medical care. At this point the particular focus of this study, Shared Decision-Making (SDM), within current general practice is introduced. A review of this work is presented alongside a discussion of the advantages and limitations of the existing work on this component of the doctor-patient relationship.

After highlighting the main issues for SDM and the consequent restrictions placed on efforts to extend the dimensions of knowledge and understanding of the consultation, the final section of this chapter will begin by proposing the need for a different perspective and method to investigate the medical encounter. It will proceed by presenting discourse analysis as a means of providing a new perspective to the study of the medical encounter as an institutional form of social action.

2.4 Medicine's societal role of agency and structure

According to Parsons (1952) illness is both biologically and socially defined and the purpose of medical institutions is to restore an imbalance in society that has been created by illness. For functionalist sociologists such as Parsons, illness is viewed as dysfunctional and, as doctors are in possession of high levels of 'technical competence', patients are dependent on them and therefore will bow to medical authority. This work argues that medicine is an institution that functions to serve society.

Foucault (1975) explored the wider context of the medical institution and reported on how power is embedded within institutional frames. He noted that in medicine, new medical techniques and practices alongside (definitive) classification of disease led to a rendering of the body as a transparent object and, in turn, gave rise to the 'clinical gaze'. Doctors were seen to have privileged access to knowledge claims that allowed them to adopt a position of scientific objectivity, which made resistance to their claims to knowledge difficult. The medical institution (the hospital structure, its practices and knowledge bases) and doctors can be seen to share a structure of identification with each other which the patient does not share and which involves relations of power and domination.

The view that it is technical competence that places the doctor in power has been disputed however. Others (e.g. Freidson, 1983) claim instead that this authority and agency is based on the doctor's 'professional' authority. Doctors are viewed as agents or 'gatekeepers' to resources such as medicines and other treatment techniques. More recently Brody (1993) has described doctors as having three powers. The first, 'aesculpian power', is based on the possession of specialized knowledge and skills in practical application. The second is 'charismatic power' and is based on interpersonal skills, and the third is 'social power' and is based on the social status of the doctor[2]. Together, these powers are seen to contribute to power asymmetry by deifying the doctor. According to Brody, the major source of this asymmetry is the result of a discrepancy between the patient's ability to assess what is required and the expertise of the doctor. One of Brody's counters to this power imbalance is 'shared power' and potentially, this can be accomplished through doctors and patients practicing a shared

[2] Brody's powers can be seen as similar to Max Weber's notion of authority e.g. charismatic, traditional and legal-rational which is linked to the rise of bureaucratic organisational structures. In Haralambos, 1991, p118.

decision-making approach to treatment decision-making. One relevant implication of Brody's ideas for the present study is that to enter into shared decision-making is to accept this sharing of power. A second counter to power imbalance in favour of the doctor is the need for participants to develop a high level of self-awareness. It would follow then, that both the patient and the doctor must reflect on their own positions of power within the consultation and how these may impact on decision-making.

2.5 Psychological approach to the medical encounter

Concurrent with the viewpoints above, different trends began to emerge that moved away from agency[3] and structural views of society towards a more local examination of the doctor-patient encounter i.e. communication practices. Emphasis on institutional power was replaced with a growing interest in the balance of power at the site of interaction.

A number of empirical and conceptual models of interaction were developed by writers (e.g. Szasz and Hollander,1956; Roter and Hall,1993). Some of these models have viewed the medical encounter as being governed by the illness or condition of the patient (e.g. Szasz and Hollander) and others connect it more to treatment decision-making and the patient's role in the encounter (e.g. Roter and Hall).

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[3] Agency refers to the possibility of choice in a situation in which there are contradictory requirements and "provides people with the possibility of acting agentically" (Wetherell et al, 2001 p270).

The models above were driven by a need to develop new methods that could consider the communication practices of (mainly) doctors. Around the same time there was an increasing call for patient autonomy as a form of 'consumer sovereignty' defined as the *"provision of information and involvement in decision-making"* and in economic terms as the 'perfect market' *"patients are the best judges of their own welfare"* (Scott, 2001 p66). This viewpoint attempts to place the patient in the position to act as his/her own agent in decision-making. Agency here contrasts with the sociological views of 'institutional' agency and the structure of society. However, Scott reports that upon close examination the theory of agency in healthcare is influenced by several factors of the professional-patient relationship. These include the extent to which patients inform the professional about their objectives and valuations of both health and non-health outcomes; the extent to which professionals inform patients on the effects of different courses of action on condition, health status and how the information is understood by the patient; and the extent to which the patient is involved (or wants to be involved) in decision-making. It is clear that in economic terms communication practices are viewed as paramount to achieving the gold standard of consumer sovereignty (or agency).

Communication practices then have come to be viewed as a requirement for good medical practice and patient satisfaction with the encounter for different disciplines and on a number of levels. These are regarded by some (e.g. Elwyn *et al*, 2001 and Stewart and Brown, 2001) as one of the essential features of the doctor-patient relationship. These views have led to considerable paradigmatic shifts and other methods of investigation were called for to match the changes in views.

It is apparent that as perspectives on medicine and the role of the doctor changed, there followed a greater focus on the actual process of interaction. As a result, the importance of patient involvement was acknowledged and the view of the patient as a partner in the consultation has evolved alongside. The next section explores interactional aspects of the consultation in further detail.

2.6 Interpersonal aspects of the consultation

The body of literature on interactional aspects or the process of communication in the medical encounter cannot be easily boxed into distinct categories although these have been broadly grouped into two main areas for practical considerations. The first of these relates to a concern with interpersonal aspects and participants' perspectives on what good communication is. The second is concerned with aspects of information exchange and the decision-making process. Boundaries become blurred however as there are a number of theoretical and methodological approaches deployed to investigate the doctor-patient relationship. Attention is directed first towards the considerations that have influenced the psychological research. Two different foci will be addressed here. The first will be in terms of psychological or cognitive components or structures of the interaction and the second, in terms of methods and measurements in place to explore the nature of the interaction.

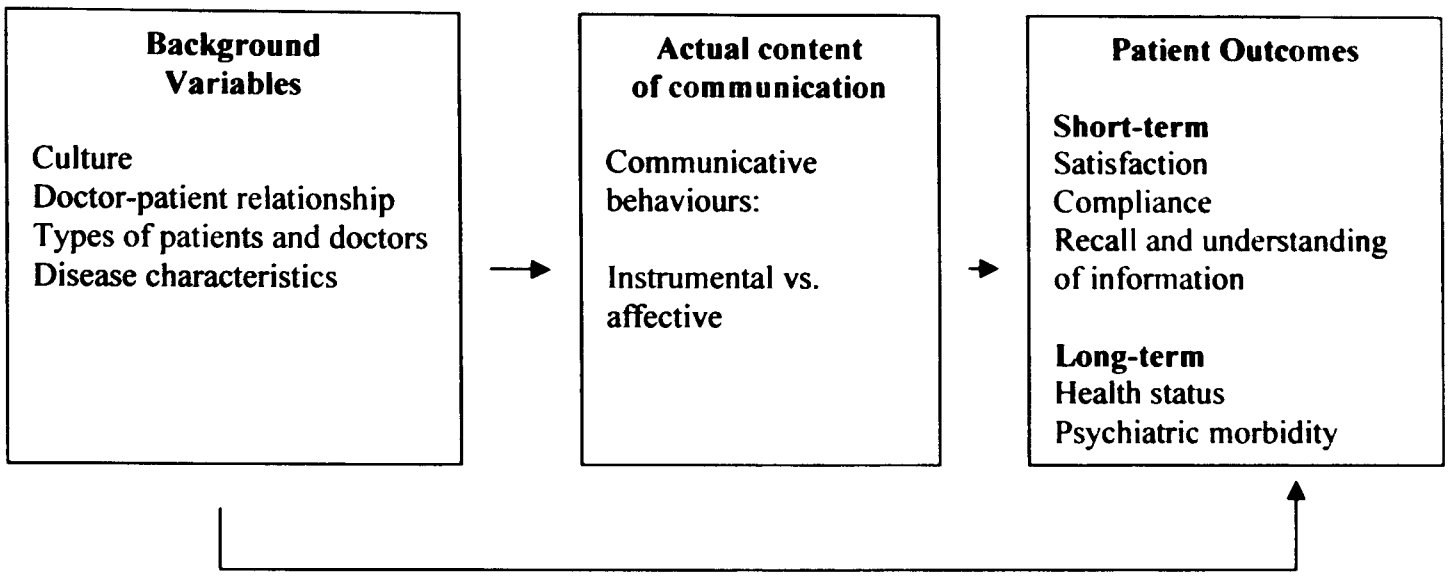
2.6.1 Cognitive components

As there is a large body of literature that adopts a psychological or cognitive research perspective on doctor-patient communication and because the present study does not

aim to build on these approaches to the consultation, two reviews that address cognitive components of communication practices are described in brief below. These reviews are not claimed to be systematic. They were undertaken in order to summarise the multiplicity of research efforts in this area. However, the reviews do provide a glimpse of the big picture and thus, are indicative of an appreciation of the complexity of studying the doctor-patient interaction.

The first literature review of the doctor-patient communication to be discussed was undertaken by Ong *et a*l (1995). This work addressed the different purposes of medical communication, the analysis of doctor-patient communication, specific communicative behaviours and the influence of communicative behaviours on patient outcomes. Within these areas the authors reviewed the treatment decision-making and communication practice literature and described how these can be measured using different interaction analysis systems. These authors concluded by proposing a framework for a systematic theory of doctor-patient communication relating to background, process and outcome variables. Figure i. describes the variables involved in doctor-patient communication that were identified as important. In addition this framework considers the process in terms of instrumental (i.e. the execution of the doctor's expertise in diagnosis and treatments) and affective behaviours (i.e. psychological and socio-emotional behaviours that establish interpersonal relationships with patients).

Fig i. Framework for systematic theory of doctor-patient communication (Ong et al 1995)



2.6.2 Measurement of cognitive components

Although there is little dispute over the variables identified, the model is underpinned by a number of assumptions. The main criticisms of conceptual models such as this one are that there is no theoretical framework guiding coding or the identification of variables (Pendleton, 1983) and that there has been a lack of corroboration between study findings (Inui and Carter, 1995). In addition, Thomson (1994) reports that the number of coding systems that have been applied has led to an unmanageable diversity of coding categories and few clear definitions. One reason given to account for this is that studies rarely address the same question in the same ways (Roter *et al*, 1988). From Ong's meta-analysis of 61 interaction analysis studies, 247 different communication process variables were identified. As a result, generalisation of findings becomes difficult (e.g. Thompson, 1994). Thus, models such as that described above can be seen to present a linear input/output model or stimulus-response approach.

A more recent review by Kiesler and Auerbach (2003) evaluated the work on doctor-patient communication as comprising two main lines of enquiry. The first of these strands identifies a line of studies that report on two particular components of the communication patterns of doctors. Similar to the work by Ong *et al* (1995) this strand also views communication patterns as comprising interwoven instrumental behaviours that address the technical or medical expertise of doctors and the affective or social components of the interaction. It is well recognised that these components or variables have been shown to continually interact with measures of patient evaluations of the encounter, i.e. outcomes (e.g. Ruben, 1993 and Mead & Bower, 2000). The second line of enquiry reported by Kiesler et al demonstrates associations between aspects of communication and outcomes in terms of primary or secondary outcomes (e.g. improvements in conditions and patient satisfaction). As a result of this kind of work a considerable effort has been undertaken to develop communication skills training programmes for both healthcare practitioners and patients (e.g. Henwood & Altmaier, 1996; Hulsman *et al*, 1999 and Kruijver *et al*, 2000).

In response to the limitations and difficulties with earlier models, Kiesler *et al* (2003) have developed an heuristic guide, the 'interpersonal circumplex', and propose that this should be utilised for future medical interaction research. This model was constructed as a conceptual and empirical tool to help integrate the numerous studies of interpersonal relationships and behaviours. These authors assert that their model offers an antidote to a deficiency in interaction analysis literature as it provides a theoretically based assessment of both the verbal and non-verbal activities within the medical encounter.

Although the reviews by both Ong *et al* and Kiesler *et al* report on limitations with interactional models of communication and suggest improvements, a number of difficulties remain. For example, interactional models such as the 'interpersonal circumplex' are underpinned by traditional cognitive or psychological constructs. Inventories are constructed that claim to provide objective indicators of personality types or dispositions. Emotional experiences are measured by the terms 'control' and 'affiliation'. In addition, these measures are regarded as having predictive validity and are claimed to foretell what is likely to happen in subsequent encounters e.g. they are "*predictive of recurrent patterns of actions and reactions that define particular dyads of interaction*" (Kiesler and Auerbach, 2003). Whilst such limitations are generally acknowledged the models such as those discussed above continue to be used to predict health outcomes, patient compliance and involvement in decision-making (Auerbach et al, 2002; Frantsive, 2002) and influence current research (e.g. Clack *et al* 2004).

Potter (1996) described three problems inherent in accepting cognitive viewpoints that can be seen to underpin the kind of outcome measures in the models discussed above. The first relates to the anti-constructionalist philosophy that views language as being 'simply' representational of inner mental states (e.g. concepts underpinning 'control and affiliation', personality traits, attitudes and emotions). The second concern is over how 'representations' become separated from the site or practices in which they are used and become conceptualised as enduring entities. In consequence, the cognitive focus diverts attention away from what is being done with talk in terms of the performative aspects of language use and therefore, prevents inclusion or acknowledgement of the reflexive and indexical properties of the talk[4]. Finally, problems occur when cognition is the topic of

[4] Here reflexivity refers to the property of talk whereby it constructs or otherwise contributes to the

the talk. Variables used to describe emotional experiences are accepted as having the same meaning for all people, and over time and different contexts. The assumption is that there is some psychological 'system', which receives, operates upon and stores 'information' about the world. For example, health or illness is taken as something that is just there rather than constructed as existing.

This viewpoint can be seen to underpin many qualitative and quantitative studies as shown in the reviews discussed earlier. To provide a further instance, Britten *et al* (2000) carried out a qualitative study exploring the nature of misunderstanding in prescribing decisions made in general practice. This study identified 14 categories of misunderstanding that occurred as a result of the lack of patient participation in the decision-making process. The categories all could be regarded as relating to problems involved in information sharing. The concerns raised by Britten *et al*, were associated with potential or actual adverse outcomes such as non-adherence to treatment. These findings buttress the core claims for developing competences underpinning the shared decision-making model. However, whilst the authors took considerable care collecting participants' interview data from different time-points, their conclusions claim coherent and objective links to the interactional activities occurring over these different points in

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sense of its own occasions and contexts. (Edwards 1996). Indexicality relates to the idea that meaning is indexical in that it changes as the occasion changes and as it is used in different situations. So, meaning is not something independent of context and use, but depends on user, context etc. The notions of reflexivity and indexicality are closely connected (Potter 1996 p47).

time. As the present study aims to describe the unfolding of the decision-making business from a social constructivist perspective, the analytic claims made by Britten *et al* can be regarded as having been based on cognitive or psychological assumptions. The various accounts provided by the participants in Britten's study, viewed from a discourse analytic perspective, would have been formulated to attend to the interactional concerns of the moment and thus claims for a particular reality over time would not be justified. There should be less surprise then at the number of misunderstandings reported when addressing the participants' accounts at different points in time. The meaning-making business for participants will be based on different agendas. Britten's study is seen to provide an example of how representations can become conceptualised as enduring entities.

The formulation of enduring concepts or constructs is not only apparent in the research world (e.g. when defining or proposing variables, constructs or concepts) but it is common to everyday talk as well (e.g. in everyday talk, attitudes and personality become constructed as enduring entities). The point is that merely listing or checking for the presence of particular attributes or events will only provide one particularly representational view of reality. Thus, for participants (including researchers) variables are constructed as factual, objective and coherent because they conform to our cultural expectations. From a social constructionist stance there will always be more than one version of reality and more than one way to look at the world. Indeed, the competing perspectives of qualitative and quantitative approaches stand testament to this. To accept only a cognitive perspective results in a limited understanding of the interaction that is underpinned only by representational assumptions of meaning.

2.7 Summary

This section has offered a glimpse into the variety of theoretical methods and models utilised in attempts to develop a deeper understanding of the nature of the medical encounter and the development of appropriate tools for the evaluation of the different components that contribute to it (from an interactional perspective). This has highlighted problems inherent with current methods that can limit greater understanding. A further issue identified related to the omission of the patients' perspective as most studies focused on the behaviour of professionals in improving communication practices. Although the patient's role has come to the fore it was noted that most studies continue to address the interaction in a one-sided way. Given that the research questions in this study aim to examine consultations as jointly-constructed 'events', this review has identified an important gap in the current research practices. However, as a great deal of the work discussed so far has come from the disciplines of sociology or psychology, the following section charts some of the historical developments and the work that has been undertaken within the academic field of general practice. Although methodologies used here have also been strongly influenced by sociology and psychology there are potential issues relating to effects of these when used to study one-to-one encounters as opposed to groups (to which much of sociological and psychological research attends).

2.8 Early work on the doctor's role in the consultation

An inspirational work entitled "*The Doctor, His Patient and the Illness*" (Balint, 1957) was one of the first to view the consultation more as a psychodynamic process. The case study approach adopted by Balint helped to identify that there was more to the doctor-

patient relationship than simply diagnosing and treating a biomedical problem (although his title suggests little consideration of female doctors). First, by recognising a need to consider the patient more holistically Balint's work stimulated an interest in doctors' behaviours and as a consequence the need for good communication skills was highlighted. Second, possession of these skills would enable clinicians to recognise and understand the interpersonal aspects of their working practices and for example the life-world views of the patients. Ultimately, this work recognised that better communication skills would help professionals develop therapeutic relationships with patients. The focus of this work has come to be recognised as one of seminal importance for the field of general practice and has influenced later approaches and informed medical teaching programmes (e.g. Pendleton et al, 1984; Neighbour, 1987). Balint's work has also had a major influence on the construction of 'personal care' as a core value of general practice (Adam, 2003 unpublished thesis).

A second pioneering study that had significant impact on the doctor-patient relationship, was undertaken by Byrne and Long (1976). Their book entitled "*Doctors Talking To Patients*" took forward the work developed by Balint. This work provided a detailed analysis or exposé of the kind of attitudes and belief systems held by doctors with different styles of consulting behaviours. These authors were perhaps first to recognise and distinguish between different styles of doctor behaviour (e.g. 'doctor-centred' and 'patient-centred'). Besides this, Byrne and Long also considered the accounts and explanations the doctors provided for their behaviours. Extract transcription was detailed and included recognition of non-verbal aspects such as laughter and body language. Although the main thrust of this work did not focus on patients talk primarily, it did provide significant analytic insight into the doctor's world.

Not surprisingly, the research questions and the methodologies have tended to mirror the one-sided approach to examination of the interaction. The role of patients and their involvement in clinical decision-making was not directly addressed. The early work from Balint and Byrne and Long addressed principally doctors' views on communication practices. The patient's views and behaviours were not of primary concern. The work carried out by these authors helped however to draw attention to the idea that the patient's contribution in the consultation was a key factor and one that was missing in research approaches.

From around the 1970s, psychosocial influences on health became increasingly accepted and the application of behavioural principles to health problems gave rise to newer disciplines such as 'health psychology' (Edwards and Elwyn, 2001). This amounted to a paradigmatic shift (Mc Whinney, 1972). Attention was given both towards the interactional process of the consultation as well as recognition of patients' perspectives on illness. Today, in general practice, the merits of traditional 'biomedical model' of medicine are now seen as having been overestimated (Yardley, 1997) and it is claimed that the 'biopsychosocial model' (Engel, 1977) has been more influential on current primary care practice and has provided the platform for patient-centred care. The next section briefly explores the theoretical underpinnings behind this movement.

2.9 Patient-centred medicine

The term patient-centred medicine was first coined in the seventies (Balint *et al*, 1970) and in the 1980s patient-centred models of consulting styles began to occupy centre

stage. The first patient-centred model was developed by Levenstein *et al* (1986) and has undergone further refinements (e.g. Brown et al, 2001; Stewart and Brown, 1986, 2003). These authors held essentially similar views for favouring a patient-centred approach. The models from Stewart and Brown encapsulate earlier work and describe six closely intertwined components which they claim are relevant for all health professions. These are:

- Exploring both the disease and the illness experience
- Understanding the whole person
- Finding common ground
- Incorporating prevention and health promotion
- Enhancing the doctor-patient relationship
- Being realistic

As can be seen the patient-centred model advocates an assessment of the biological process of disease together with a consideration of the effects of illness on individuals, their family and their world. For the clinician the aim is to understand the patient's unique experience of illness by *"entering the patient's world"* (Edwards and Elwyn, 2001 p7). In order to adopt a patient-centred approach clinicians have had to have a major re-think about their roles. This has led to a rejection of the predominantly one-sided approach where clinicians were expected to be in control of and responsible for treatment decision-making. Instead clinicians have been required to develop a different 'mind-set', with new conventions underpinning their working practices and relationships with patients. This has involved fostering an atmosphere of partnership between participants in the medical encounter and can be seen today in medical

teaching departments with 'disease-illness' models underpinning the curriculum. particularly in general practice (as opposed to the once traditional biomedical model).

This change in focus from doctor-centred to patient-centred models of care has led to paradigmatic shift in approaches to health care which in turn have led to changes in both policy and practice. As a result, the development of the concept of *'evidence-based patient choice'* (EBPC) is now centre stage. Ashcroft *et al* (2001) have reported this movement brings together two important changes in modern medicine. First it addresses the paradigm shift in medical practice referred to above. This contrasts with earlier practice that placed the authority for decisions with the doctor. The second major change reported by Ashcroft *et al* (2001) relates to the implicit issue that hitherto patients were regarded as passive recipients, who now are required to have a central role in decision-making in order to protect themselves from excessive paternalism. As a result of the socio-political changes it can be concluded, that in order to practice EBPC, decision-making models will need to reflect these two concerns. It is recognised that models of shared decision-making meet these requirements. Underpinning this more inclusive approach is the implication that the power of the traditional biomedical approach will be eroded and, with this, so too the power of doctors. The ways in which these models can be seen to incorporate EBPC are discussed next in the review of the literature advocating the shared approach to treatment decisions.

2.10 Models of Shared Decision-Making

Before describing models of shared decision-making the term needs to be defined and set in context. Treatment decision-making has been described in terms of three

approaches: the paternalistic, the informed and the shared. In simple terms, the paternalistic model involves clinicians making and taking responsibility for decisions and, in its most extreme form, denies patient autonomy. In the informed model patient autonomy is paramount and after providing information, the clinician withdraws having provided no recommendation in order to allow the patient to make an informed choice. Shared decision making is seen to occupy the middle ground by making patient autonomy optional. In this model, patients who wish to be involved will make health care decisions that are informed by the best available evidence, their personal preferences and supported by their doctor.

2.10.1 Frameworks for teaching SDM

One of the first conceptual teaching frameworks for shared treatment decision-making was developed by Charles et al (1997). This model described four requirements for a shared treatment decision.

- First, both the patient and the doctor are involved.
- Second, both parties share information.
- Third, both parties take steps to build a consensus about the preferred treatment.
- Fourth, an agreement is reached on the treatment to be implemented.

Focusing on the first two features of the model, Stevenson *et al* (2000) used this model to consider participation in consultations in terms of information sharing relating to medicines. Using data from 62 consultations and patient interview dyads these authors concluded that participants did not share information in such a way as to enable

treatment decision consensus. This study highlighted some of the barriers to sharing decisions that were also recognized in other studies. The next section describes some of the work that was carried out in order to respond to some of the barriers identified.

2.10.2 Competences required for teaching SDM

Towle and Godolphin (1999) refined the work on shared decision-making frameworks and described a model '*for teaching and learning informed decision-making*' that attends to the interactive process more clearly than earlier models. Their framework describes particular characteristics or 'competences' needed for engagement in the practice of 'informed' shared decision-making. Competences refer to the knowledge, skills and abilities that *"represent the instructional intents of a programme, stated as specific goals"* (Towle and Godolphin, 1999). Here, 'informed' infers that the decisions have also been informed by best evidence. However, these terms are seen as neutral descriptions rather than as constructed and contested versions. The implications resulting from this will be returned to later in the review, particularly when discussing the analytic approach adopted for this study.

Table 1 below provides a list of the competences required of the doctor to enable informed shared decision-making. It is suggested that this list includes all the factors or aspects that doctors need to consider for their part in accomplishing an informed shared decision. It may be seen as a list of required ingredients but it does not explain how to go about collecting, measuring and combining the ingredients. To continue with the 'recipe' metaphor this does not provide direction as to how doctors actually learn to bake the cake.

2.10.2.1 Table 1 Competences for physicians for informed shared decision-making

1. Develop a partnership with the patient
2. Establish or review the patient's preferences for information (such as amount or format)
3. Establish or review the patient's preference for role in decision making (such as risk taking and degree of involvement of self and others) and the existence and nature of any uncertainty about the course of action to take
4. Ascertain and respond to patient's ideas, concerns, and expectations (such as about disease management options)
5. Identify choices (including ideas and information that the patient may have) and evaluate the research evidence in relation to the individual patient
6. Present (or direct patient to) evidence, taking into account competences 2 and 3, framing effects (how presentation of the information may influence decision-making), etc. Help patient to reflect on and assess the impact of alternative decisions with regard to his or her values and lifestyle
7. Make or negotiate a decision in partnership with the patient and resolve conflict
8. Agree on an action plan and complete arrangements for follow-up

**Informed shared decision-making may also: Involve a team of health professionals, others (partners, family) and differ across cultural, social and age groups*

From Towle and Godolphin, 1999

Towle and Godolphin recognized the need for patients to be equipped with the appropriate skills to enable fuller participation in the decision-making process and also developed a list of competences for patients (Table 2). These authors had also held the view that the contributions to be made by patients should not simply be seen as desirable but are actually necessary. In addition, they had identified a concern that

should patients' abilities (or responsibilities) be excluded then doctors will continue to perpetuate a paternalistic relationship.

2.10.2.2 Table 2 Competences for patients for informed shared decision-making

1. Define (for oneself) the preferred doctor-patient relationship
2. Find a physician and establish, develop and adapt a partnership
3. Articulate (for oneself) health problems, feelings, beliefs and expectations in an objective and systematic manner
4. Communicate with the physician in order to understand and share relevant information (such as competency 3) clearly and at the appropriate time in the medical interview
5. Access information
6. Evaluate information
7. Negotiate decisions, give feedback, resolve conflict, agree on an action plan

* *Preliminary list*

From Towle and Godolphin, 1999

With this list the authors highlight the potential contributions patients themselves can bring to the doctor-patient relationship. However, as these lists have been theoretically derived it remains unlikely that the professional understanding of the terms e.g. 'access' and 'evaluate' will have the same meaning for the majority of patients. This discrepancy between professional and 'lay' understandings may have a negative impact on the decision-making setting. In particular, the potential problems that may be encountered relate to the expectations doctors would have of patients and their abilities to be 'competent' and 'active participants'. It may be less an issue of teaching participants the communication skills necessary to participate in 'sharing' than of breaking established patterns of interaction and power differentials. It is suggested that more work is needed

to explore further the interactional strategies that allow shared decision-making to occur in order to define and refine the process as has been suggested (e.g. Enswistle *et al*,1998; Towle & Godolphin, 1999; Coulter *et al*, 1999). This competency framework holds the view that there should be at least two participants involved in the decision-making process and reaching shared decisions should not be regarded as the concern of only the doctor. However, whilst the identified competences are desirable and indeed necessary this model does not wholly encapsulate the view that the decision-making setting is a site of joint production. As a result, it does not provide any instruction as to how to combine the participants' roles. What this model omits is the recognition that decision-making and patient participation will be the result of the emergent process of the interaction rather than by following the steps through a prescribed list of competences.

In some ways, attempts at resolving this concern can seem like trying to piece together a jigsaw or having the correct cement to build a wall. However, the next section discusses the research attempts at addressing the underlying theoretical issue by looking at ways to attend to the practicalities involved.

2.11 Building bridges

In the main, studies have included key informant interviews and observational enquiry (Elwyn *et al*, 2001). Key informants are chosen because they have a special interest, knowledge, status, or skills and access to perspectives otherwise denied to a researcher (Goetz and le Compte, 1984). A study by Elwyn et al (2000) using this approach was carried out between the theoretical ideas behind shared decision-making to provide a

bridge with what happens in actual practice. This exploratory study involved holding a number of focus groups over a three-month period with experienced GPs who had been involved in assessing consulting skills competences and who were also involved in teaching undergraduates or postgraduate medical students. From this study a sequence of doctors' skills for involving patients in healthcare decisions was proposed as follows.

1. Involve patients implicitly or explicitly in the decision-making process
2. Explore ideas, fears, and expectations of the problem and possible treatments
3. Portray equipoise and options
4. Identify the preferred data format and provide tailor-made information
5. Check process: understanding of information and reactions (e.g. ideas, fears, and expectations of possible options)
6. Accept process and decision making role preference
7. Make, discuss or defer decisions
8. Arrange follow-up

Although the clinicians involved in this study viewed patient involvement as a requirement of good medical practice, the skills needed to successfully share decisions were seen to present a major challenge to the clinical consultation process in practice. These authors state that the skills required need to be given much higher priority than exists at present.

2.12 Professional-patient dyad model

Arguably, the most up-to-date theoretical and empirical framework comes from Elwyn and Charles (2001). This model has been influenced by the work cited earlier and incorporates further refinements to the earlier models. As is shown in Table 3 (p42), decision-making is described as comprising three analytic phases: information exchange; deliberation; and treatment decision. The phases of the shared decision-making approach will be discussed in order.

As illustrated, SDM can be seen as an interactive involvement between health professionals and patients in the process of decision-making and therefore, the ownership and responsibility for decisions is also shared between participants. This model then can be seen to include the key requirements of sharing treatment decisions.

Table 3 Models of treatment decision-making

Analytical Phase	Models	Paternalistic	Shared	Informed
Information exchange	Flow direction	One way (largely) professional	Two-way professional and patient	One way (largely) professional
	Type	Medical	Medical and Personal	Medical
	Amount	Minimum legally required	All relevant for decision making	All relevant for decision making
Deliberation		Professional alone or with other professionals	Professional and Patient (plus potential others)	Professional and patient (plus potential others)
Deciding on treatment		Professional	Professional and patient	Patient

Illustration for an encounter focusing on a professional patient dyad (Based on Elwyn and Charles, 2001 p220)

2.12.1 Analytic phase 1 - Information exchange

Elwyn and Charles (2001) describe the first analytic phase as 'information exchange'. Here attention is given to the content and interactional flow of the information shared by participants. In this phase the doctor is considered responsible for providing the patient with all of the appropriate information relating to the available treatment options including the risks and benefits of each. It is expected that patients will enlighten the doctor by providing information relating to their worldviews and lifestyles so that the doctor can assess and evaluate these factors in terms of proposing appropriate and available treatment options.

2.12.2 Analytic phase 2 – Deliberation

This phase involves establishing the preferred treatment options alongside discussion relating to the consequences of choosing on particular treatments. Underpinning this is the assumption that both participants have a rightful investment in the treatment decision so the views or preferences of both participants will be taken into account in order to reach a consensus over treatment. When there is a disagreement the decision will need to be negotiated with the aim of reaching a solution that both are satisfied with. If this cannot be achieved the doctor may have to make a compromise in order to accept the patients' views. One potential difficulty for doctors will be in learning to accept that patients may not always want to choose the treatment, which they view as 'right'. The implicit economic issues will also need to be considered here.

2.12.3 Analytic phase 3 - Reaching a treatment decision

This phase requires the doctor and patient to reach a consensus on the particular treatment to be implemented. If there is no consensus then the treatment decision cannot be described as shared although the earlier analytic phases may still be.

2.13 Discussion

From an examination of this model it becomes clear that 'sharing' can potentially occur within the different phases. As can be seen, the shared model continues to describe a theoretical process of decision making between the patient and the doctor. This model advocates patient autonomy and consequently, the accomplishment of treatment decisions will in theory encapsulate participants' value judgements about risks and benefits as well as incorporating the evidence-based practice movement. Whilst this model may be seen to build on the earlier models by e.g. attending to the 'flow of information', there remains a practical question in how the degree of sharing can be determined. Nor can it be determined with any degree of certainty which phase ultimately constitutes the overall accomplishment of the decision and its level of 'sharedness'. However, the authors do recognise and highlight some of these and other limitations (e.g. they report a lack of information or knowledge relating to the extent to which the shared approach is practised; admit confusion over what SDM actually is; agree there are potential problems for the model owing to overlaps in approaches as professional behaviours are unlikely to conform to one particular approach; and identify concerns with doctors' abilities to develop the communication skills necessary). Further, although reporting an increased pressure on professionals to practise this shared

approach to treatment decision-making, Elwyn and Charles (2001) also indicate that this approach may be more suited to particular clinical areas (e.g. where the condition is more serious or life-threatening; where there is no clear best treatment available; where the treatment option has both benefits and risks requiring trade-offs and where preferences for different health states and quality of life are important factors in the decision-making process (p122)). Other concerns reported by these authors relate to the assessment and evaluation of patient participation. Having developed a tool to measure professional involvement (OPTION) Elwyn *et al* (2003) have called for the development of suitable tools that can be used to evaluate the level of patient involvement in the decision-making of the SDM consultation. The next section comments on the literature on the current interventions and measures in place to facilitate and examine patient involvement.

2.14 Interventions to facilitate patient involvement in the decision-making process

2.14.1 Providing patients with information

It has been recognised that patients cannot fully participate in the decision making process unless they are given the appropriate information about their condition, outcomes and the choice of treatments available. Coulter *et al* (1999) recruited 62 patients (with personal experience of the specific health problems) and 28 clinical or academic specialists to review 54 'information' articles (produced by various sources such as NHS, voluntary organisations and drug companies etc). The authors conclude that current information materials can be patronising, omit relevant data and fail to give a balanced view of the effectiveness of different treatments. Similar reports have been

found in other work e.g. Raynor and Britten (2001). What becomes apparent from this issue is there will always be some disagreement over claims for what is balanced. The point being made here is that what constitutes 'relevant data' will be up for negotiation.

In addition to written information, other mediums used to provide healthcare information have arisen from developments in information technology (IT), e.g. the World Wide Web (www) and the internet. Potentially, the ability for patients to access information directly can facilitate partnership in health care and evidence-based patient choice. Whether or not this makes it easier for doctors or patients to engage in shared decision-making is not always clear however. Eysenback and Jadad (2001) have reviewed the current barriers to further information for consumers. They have concluded that in spite of a trend towards sharing treatment decisions consumers continue to have to interact with paternalistic providers (i.e. practitioners and the inherent concerns over the 'commodification' of healthcare). Thus, healthcare practitioners may discourage patients from accessing healthcare information. Eysenbach *et al* also point out that many professionals have a low regard for the internet as an educational tool but report that this may be more to do with a lack of quality control on the information available than paternalistic practitioners. Other concerns with IT information relate to the numbers of patients who are unable to subscribe to the internet or use this medium to good effect. Arguably, these patients will be less equipped to participate fully in treatment decision-making and may have little choice but to depend on their GP. Cox (2002) undertook a questionnaire survey of GPs' views on the impact of the internet on the doctor-patient relationship. The questionnaire addressed three particular areas.

1. Clinicians' perceptions of the impact of the internet on the doctor-patient relationship.
2. Clinicians' feelings about meeting a patient who has gathered information using the internet.
3. Clinicians' beliefs about the impact on patient consultation of information on the internet.

Cox found that 76% of respondents (423/553) reported that the internet has affected the doctor-patient relationship. The majority reported that the patients' use of the internet challenges their knowledge (86%) and challenges their authority (65%) but empowers patients (83%) and provides an opportunity to developed shared care (70%). The majority of respondents characterised internet-informed patients as 'interested' (78%), providing an opportunity to learn (75%) and as an opportunity for partnership (78%). With regard to their perceptions of patient internet usage 42% believed less than 5% of their patients used the internet for medical information. The majority of respondents also reported a lack of awareness of guidelines identifying appropriate internet sites for medical information. Cox suggests that GPs do not feel equipped to deal with internet-informed patients who may be empowered in the consultation and may challenge GPs' knowledge. This work suggests that there are potential gains and losses for the clinician in terms of an erosion of professional status and for the doctor-patient relationship in general. It appears from the work by Cox that GPs believe most gains will be for the patient (one aspect not directly addressed this study and that may be interesting to explore relates to GPs' attitudes towards practising shared decision-making).

Other technological advances are seen as having the potential to encourage patients' access to information. There has been a recent trend towards the development of computer software packages that can be used by the doctor and patient within the consulting room to assist in treatment decision-making (such as decision analysis and risk evaluation tools e.g. Protheroe, 2000); Elwyn *et al*, 2001); Murray et al, 2001). A major concern exists however, over patients' understanding of risk and in how it is conveyed. Doctors have three statistical representations that can be used to measure the gains in risk reduction from different treatments i.e. 'absolute risk', 'relative risk' and 'numbers needed to treat (NNT)'[5] (Misselbrook & Armstrong, 2002). These authors highlight a potential discrepancy between patients' and doctors' understanding of risk that is likely to have negative consequences on patient autonomy and that may result in a greater dependency on doctors. Walter and Britten (2002) found that women's understanding about the risks involved in hormone replacement therapy were evaluated by placing knowledge, context and presentation against personal experience and core beliefs. Thus, patients' risk understanding was found to be a complex business. To improve on risk communication, the authors concluded that consideration should be given to the patient's perspectives on language, framing and a personalised approach as well as the effects of severity, lay beliefs and emotions caused by the risk under discussion. Edwards (2003) writes that in spite of approaches that try to enhance the communication of risk (by developing communication skills, using decision aids, and simplifying the representation of information), when clinicians talk about actual risks

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[5] ***Relative risk reduction or increase:*** Increase in events with treatment compared with control (treatment) or reduction in events with treatment compared with control (prophylaxis); this number is often expressed as a percentage. ***Absolute risk reduction:*** Difference in event rates for two groups, usually treatment and control. ***Number needed to treat:*** Number of persons who must be treated for a given period to achieve an event (treatment) or to prevent an event (prophylaxis). The NNT is the reciprocal of the absolute risk reduction. McQuay & Moore (1997)

with individual patients they often use analogies. Edwards has collected a number of analogies used by colleagues which illustrate some of the more practical ways risk can be conveyed in practice. One problem that has been identified is that analogies may not be viewed as evidence-based (Ghosh, 2003). However, the use of analogies provides an example of a different kind of risk tool that doctors have at their disposal to represent medical risk i.e. the deployment of an alternative discourse. The inferential resources contained within analogies can be used as an effective rhetorical construction to convey the sense of a shared meaning or understanding.

In addition to the more technological tools, a variety of media is being used to provide health information to patients. For example, television channels dedicated to health and healthcare, TV doctors, medical soaps and interactive discussion and debate are easily accessible. A good deal of magazine content is given over to informing the public on health related issues. Taken together, these forms of information provision make it likely that patients will be more informed about the nature of different diseases, the effects of illness, trends in treatment etc. Not only are patients potentially more informed[6] they may also be more aware of the political ramifications of costs and benefits, and trade-offs in healthcare within and between different societal structures (e.g. medicine and the politics underpinning practice) will become much more visible and transparent to 'consumers'. As a result doctors may have no choice but to include these factors.

However, in spite of the technological tools available to encourage patient participation, reliable outcome measures on patients' involvement are scarce. Concerns remain over

[6] It may be also be the case however that patients may, at times, be misinformed. This may be of concern to doctors.

media access and quality. In addition. it has also been claimed that owing to the power dynamic it is the professional who ultimately grants 'involvement' (Ainsworth-Vaughan, 2003). Should this be the case then researchers and clinicians will need to consider this when developing strategies aimed at encouraging patient engagement in decision-making. The next section provides an overview of other methods currently used to measure aspects of patient involvement.

2.14.2 Measuring involvement

It can be concluded from the section above that a direct concern for healthcare researchers is establishing the level and quality of patient involvement in decision-making affecting their own healthcare. Elwyn et al (2001) reported that existing outcome measures are problem and undertook a systematic review of existing instruments that are in circulation to measure the extent to which health professionals involved patients in SDM.

This review was underpinned by two main assumptions. First, 'involvement' is a negotiated event and second, legitimate 'choices' exist in most clinical situations. Thus. in order to measure involvement attention must be focused upon the degree to which health professionals offer choices and invite patients to become involved in decisions about their own treatment. The authors argue that this process has to be measured accurately in order to establish the degree of patient involvement and how this accords with the most effective 'participatory' behaviours. Studies were identified on the basis that they involved observational assessments of actual consultations and that these included assessments of the aspects of involving patients in the process of decision-

making. Seven instruments meeting the inclusion criteria were identified in all. These are listed in Table 4.

Table 4 Instruments identified by Elwyn *et al* 1999 as measures of patient involvement

Instrument	**Author**
Calgary - Cambridge Observation Guide	Kurtz, 1996
Communication and Decision-Making Checklist	Makoul, 1992
Elements of Informed Decision-Making	Braddock, 1997
Euro-communication Scale	Mead, 1999
Levels of Physician Involvement (LPI)	Marvel, 1993
MAAS-Global	Van Thiel, 1992
Patient-centredness: Component 3: Finding common ground	Stewart, 1995

These instruments were evaluated as measures of patient involvement in decision-making in terms of their development, validity and reliability. This systematic review identified that the development and testing of the instruments have been primarily psychometric in nature (i.e. measurements of attitudes or personality etc). The authors concluded that the existing tools do not measure the construct of patient involvement comprehensively. It was reported that this is because they were not specifically developed to focus on 'involvement', many having originally been developed as generic measures e.g. patient satisfaction and some positioned within a paternalistic paradigm of interpersonal communication.

Having reviewed the literature on questionnaire based outcome measures relating to patient satisfaction in general (for the purposes of data collection for the present study),

it was indeed identified that the majority of existing instruments were developed to encompass the concept of patient-centredness (Little et al. 2001). As most measures of patient centredness can be shown to relate to a small proportion of the decision-making context, existing instruments are unlikely to identify consultations where decisions had been shared (although it has since been argued that patient-centredness and shared decision-making can be differentiated (Wensing *et al,* 2002).

Edwards et al (2001) set up a focus group study that aimed to identify the outcome measures of consultations that were regarded by patients as important. These authors compared their findings with those reported in current literature. The results showed that, first, patients did not identify all of the outcomes. Second, patients did not consider some of the outcomes to be important and third, patients identified a broader range of outcomes as important that are not already considered in the existing outcomes e.g. 'feeling 'respected', 'reassured', 'supported by professionals' and 'comforted' with the knowledge of continuity of care. The authors reached the following conclusions. First, future research needs to evaluate interventions such as training in terms of those outcomes most important to patients and second, the types and range of outcome assessments need to be reviewed. These findings are expected to contribute to the discussion over whether or not future research should be driven by patients or professionals needs. The authors also state that some of the barriers to the construction of suitable instruments relate to different constructs of 'involvement' and instruments need to identify the specific construct they are derived from. Thus, according to these authors, at present there are no valid and reliable tools to measure patient involvement because in part, patient participation has not been defined precisely enough to allow specific measurement.

The difficulty in addressing these issues comprehensively rests with the continued acceptance of a positivistic and representational view of language. Intrinsic to this view is the expectation that it will be possible to pin down and agree on 'universally' accepted definitions and categorisations. What this view omits to consider is that variability is inherent in the construction of measurements and categories and therefore, enduring qualities will not always exist. Rather, they can only be constructed in order to provide a particular version of reality. The consequence of this for GP and medical practice is that research findings and measurements will not always map onto 'real' life and therefore theoretical models may become bankrupt in the medical encounter.

2.15 Summary

It is clear from this review that researchers with a firm belief and interest in the shared approach to treatment decision-making recognise a number of weaknesses in the current outcome measures. These have important implications for the future of SDM. For example, training programmes in consultation skills will not be informed by robust and rigorous methods for teaching until some of these weaknesses have been resolved.

This review reports claims that there are no reliable measures available for assessing the level of 'involvement' and that 'sharedness' is also a difficult concept measure. Studies are unable to assess adequately what aspects of shared decision-making patients want. Kinnersley et al (1999) found that although there appears to be general support for these strategies there is little evidence of the outcomes of such approaches as beneficial for patients. This is, of course, tautological, as patients cannot evaluate a process until

they have experienced it, and clinicians are only beginning to develop the skills necessary for shared decision-making to take place. Overall then, little is known about the form of or the extent to which shared decision-making is practised. In part, this is because there is confusion and disagreement about the defining characteristics and also because it is likely that professionals' behaviour will not always conform to any singular 'ideal type' (Elwyn and Charles, 2001).

Taking all these concerns into consideration, it does appear that there are a number of limitations with SDM models and also barriers to its successful implementation. Most of the difficulties however, can be seen to have less to do with the methods *per se* but rather, arise from two main factors. The first involves the perception that the doctor-patient interaction is a (singularly) cognitive or psychological event and the second relates to a kind of taken-for-granted view that the consultation is an interaction *between* two agents rather than as a co-constructed event. If treatment decision-making continues to be regarded in these ways only, the limitations and barriers discussed above will be perpetuated. Addressing one participant's contributions in isolation from the other, and in cognitive terms, will act as a barrier to investigation of the SDM process and also limit our understanding into the nature of it. Methodological approaches that can consider the interaction, as a joint discursive activity may be able to begin to redress the difficulties discussed above. The next section will discuss a further concern, relating to the cognitive perspective with particular regard to the development of communication skills, before concluding this review and moving on to explore alternative approaches.

2.16 The cognitive perspective and the development of effective communications skills

So far this review has addressed only indirectly, an ever-present concern over the acquisition of appropriate communication skills for SDM. As already reported in this review, good communication skills are seen as paramount for a therapeutic doctor-patient relationship: it is useful to briefly examine the basic premises underpinning the development of communication skills.

It has been claimed that interpersonal skills can be defined, deconstructed and taught (Argyle, 1994; Hargie, 1997). In describing the process of learning how to interact with patients in an SDM setting, Elwyn and Charles (2001) base instructions on the acquisition of a social skill (e.g. communication) as a *"process whereby the individual implements a set of goal-directed, interrelated, situationally appropriate social behaviours which are learned and controlled"* (Hargie,1997).

(In Elwyn and Edwards, 2001 p124)

The critical educational components for Elwyn et al are that '*behaviours are learned and controlled*'. These authors appear to support the view that after repeated exposure to the same situation individuals formulate cognitive 'schemas' and learn 'scripts'. A schema is an organised packet of knowledge that enables us to make sense of new knowledge (Bartlett, 1932), and scripts are a special type of schema representing knowledge of routine actions and familiar repeated sequences (Harley, 1996). Essentially, scripts inform us on what to expect and how to behave in particular situations. For example, children as young as 2 or 3 years know what to expect at a

birthday party or a visit to MacDonald's, and they know too what is expected of their own behaviour in these environments. The inference from this is that professionals will learn particular scripts or a set of behaviours when interacting with patients. The same will be true for patients. This could involve the acquisition of turns of phrase which have been learned from other colleagues and which are 'triggered' by events and deployed to deal with familiar situations. Scripts then can be seen as a repository of automatic responses called upon to perform particular functions, with the expectation that their deployment will result in particular behaviours. Whilst schemas and scripts can be useful in explaining experimental results in social psychology and can possibly account for the phases repeated in a medical consultation, they are unable to offer a clear explanation about the process of accomplishing a shared decision or how patient 'involvement' is actually generated through the interaction and the talk involved. It is these concerns that the present study aims to explore. However, schemas and scripts are not seen as the only factors that contribute to the development of communication skills. Other psychological and cognitive measures can be employed too, e.g. personality profiles.

A recent study by Clack et al (2004) has proposed that communication between doctors and patients can be enhanced if medical education incorporates training in how personality type differences between participants can affect the outcome of an interaction. These authors suggest that in order to accomplish effective communication a 'meeting of minds' needs to occur and that the Myers-Briggs Type Indicator (MBTI) can be used to help characterise differences and similarities in how people process information discussed regularly within the medical interaction. The authors report that this measure has identified that when communication style preferences are similar or are

adjusted to incorporate the styles of others then satisfaction outcomes are greater. In the study, the MBTI was administered to 464 UK medical graduates and the resultant profiles were then compared to the personality preferences of a representative sample of the UK adult population (based on a survey carried out by the Office of Population, 1996). It was concluded that within the four basic personality dimensions[7] (and allowing for gender differences) there were significant differences between the UK adult norms and the medical graduates over three of the four dimensions[8]. The authors suggest that when individuals (doctor and patient) differ to such an extent, it is likely that misunderstandings will arise within the interaction. For example, patients with a preference for the dimension of Sensing and Feeling (40.1% of the UK population) will have only a 1 in 6 chance of seeing a doctor with the same preference. Similarly doctors' with a preference for Intuition and Thinking (33% of Clack *et al's* sample) will have only a 1 in 11 chance that patients' will share their preference. Whilst the authors acknowledge that contextual factors will affect the nature of communication they do suggest that their findings (if generalisable) could have considerable relevance to doctor-patient communication. They conclude that educating healthcare workers on personality differences and teaching 'flexibility' can result in better outcomes for both participants in the encounter.

Findings such as these from Clack *et al* (2004) can be seen to provide a particular form of knowledge. However, to reiterate the claims made throughout this review, methodological approaches based on cognitive or psychological measurements are not able to provide specific information on the ways the medical interaction unfolds. In other words, concepts such as scripts and schemas and personality traits are not able to

[7] Extraversion/Introversion, Sensing/Intuitive perception, Thinking/Feeling judgement, Judging/Perceiving orientation.
[8] No significant differences found on Extraversion/Introversion dimension.

inform further on the explicit process and activities involved when negotiating a decision. Thus, the contributions from cognitive or psychologically based methods are not best placed to provide satisfactory insights into how communication skills can be improved or taught nor do they provide a means to explicate on the decision-making process.

This section has again highlighted limitations with using cognitive or psychological models to understand aspects of the doctor-patient interaction and thus, reaffirms that the dependency on cognitive perspectives can be seen as a key barrier to extending knowledge and understanding of the shared decision-making approach to the medical encounter. Thus, there is a clear need for research that can examine and address these issues. This review concludes with a brief summary before moving on to suggest how the present study offers a means of addressing the concerns discussed above.

2.17 Discussion

The variety of literature reviewed acknowledges that SDM can be approached from different perspectives, and differences in perspectives will provide different ways of understanding the doctor-patient interaction. The review has identified and established that, within the field of general practice, it is not clear how to describe the shared decision-making process. Attempts to investigate the various aspects of SDM are limited because of difficulties in constructing reliable tools to measure or evaluate it. Models tend to be theoretical and not empirically derived, are problem and are not seen to accord sufficiently with the patients' perspective. Having provided some examples of the issues identified in the current literature, the main finding of the review suggests that

many of the limitations have arisen first. because the traditional approach tends to examine only one participant's contributions or actions within the decision-making event at a time and second, the methods currently favoured can be seen to have cognitive or psychological underpinnings.

As a result of this review, it can be concluded that there is a need to explicate upon the nature of shared decision-making, i.e. describe and explain what SDM actually is and how it is accomplished. In order to do this an alternative theoretical and/or methodological perspective is required. In short, an approach that is able to provide the potential to explore the contributions and activities of both participants, as a jointly produced event, is necessary.

One broad approach that offers the means of examining the conversational activities involved in SDM is discourse analysis. This approach lends itself to viewing, for example, 'personality traits' as emergent properties of the interaction and not as pre-existing components. Chapter 3 explores the utility of discourse analysis as providing a means of explicating the nature of shared treatment decisions by examining the discursive activities involved and as a process of joint production.

CHAPTER THREE

Re-Conceptualising the Shared Decision-Making Encounter as a Discursive Event

3.1 Introduction

The aim of this chapter is to position and describe the major methodology used in this study. It begins by locating this within a social constructivist philosophy. Next, it introduces discourse analysis (DA) by presenting some descriptions and definitions of discourse and discourse analyses before charting the historical and philosophical background that has laid the foundations for the analytic method chosen. Following this the chapter moves on to describe in some detail the theoretical framework underpinning the method of analysis chosen and provides the reason why this method is deemed as most suitable for investigation into the nature of shared decision-making. After re-conceptualising the medical consultation as a discursive event, this chapter concludes by introducing the study's broad aims and the research questions.

3.2 The social construction of the medical encounter

As the aim of this study is to explore and describe how shared treatment decisions are accomplished through a process of joint production and constructed locally, a social constructivist position has been adopted. This position holds that knowledge is the result of social interaction and language usage, and thus is a shared, rather than an individual,

experience. Therefore, it denies the existence of an objective knowledge since *"there are many ways to structure the world, and there are many meanings or perspectives for any event or concept"* (Duffy and Jonassen, 1992). In addition, this social interaction always occurs within a socio-cultural context, resulting in knowledge that is bound to a specific time and place. This position is exemplified with the words *"truth is not to be found inside the head of an individual person, it is born between people collectively searching for truth, in the process of their dialogic interaction"* (Bakhtin, 1984 p110). For Bakhtin, truth is *"neither the objective reality of the cognitive constructivists nor the experiential reality of the radical constructivist, but rather is a socially constructed and agreed upon truth resulting from co-participation in cultural practices"* (Collins, 2001).

Shotter and Gergen (1984) have reported that social constructivism can be seen to have given voice to a range of new topics, such as the social construction of personal identities; the role of power in the social making of meanings; rhetoric and narrative in establishing sciences; the centrality of everyday activities; remembering and forgetting as socially constituted activities; reflexivity in method and theorizing. These authors further conclude that the common thread underlying all these topics is a concern with the processes by which human abilities, experiences, commonsense and scientific knowledge are both produced in, and reproduce, human communities (Shotter and Gergen, 1994 p.i.).

In other words, social constructionism rejects traditional cognitive viewpoints that explain actions or events as a consequence of mental processes or entities. Language use characteristically has been seen as a source from which information about how people

think or feel can be learned. For example, when patients describe their symptoms to the doctor it might be said that they are simply providing a stock of information from which the doctor may offer a diagnosis and prescribe a particular treatment. The social constructivist perspective argues that patients and doctors will be doing much more with their descriptions and reports than simply providing information. Participants will also be accomplishing particular social actions by constructing particular versions of themselves, other and events (e.g. exonerating, justifying).

This utilisation of discursive resources and strategies to achieve different social actions is to a large extent bound up with the management of accountability. For example, Edwards (1994) analysed telephone conversations and identified features in the ways events were often reported as routine, dispositional or attributed to external pressures etc. Hence, even 'ordinary' descriptions and mundane talk are seen to accomplish particular activities, such as managing blame, attending to issues of personal stake and warranting particular courses of action. Gergen (1985) has argued that the basic tenets underpinning social constructionist approaches include:

1. a radical doubt in the taken-for-granted world
2. the viewing of knowledge as historically, socially and culturally specific
3. a belief that knowledge is not fundamentally dependent on empirical validity but is sustained by social processes
4. and a view that descriptions and explanations of phenomena can never be 'neutral'

Social constructivism can be seen as the antithesis to objectivist underpinnings of traditional scientific investigation. It is for these reasons that the methods underpinned by this stance offer promise with regard to directing attention to some of the research and practical problems identified in Chapter 2.

Thus, the main divergence from traditional psychological methods of enquiry offered by discourse analytic approaches is that they hold that language is used to construct versions of reality that in turn construct and create the social world and language use is not simply representative of psychological states or traits (i.e. attitudes or personality types). Language use is seen to be action-oriented and can be used to perform particular tasks in order to attend to local and immediate concerns such as dealing with issues of personal stake and accountability. However, there are a variety of analytic approaches available. The methodological approach taken in the present study needs to be positioned in relation to the theoretical framework of discourse analysis in general. The next section provides a discussion of the definitions of discourse and discourse analysis.

3.3 Discussions and definitions: 'discourse' and 'discourse analyses'

The term discourse can be used to mean a number of things. For example, it can be used to refer to talk and textual materials; can be used to describe narratives; can be taken to mean a set of 'rules' governing an understanding of something; a certain mode of talk which represents a particular power or dominance (such as liberalism, third way politics, or racism). When choosing discourse analysis, the issue for the researcher is to make a decision at the outset over what the term discourse is taken to mean and what

kind of discourse analysis will be most appropriate for the aims of the study. The next section sets out the context for these decisions in the present study.

The following descriptions illustrate the different theoretical and philosophical premises that discourse analysis has been embedded within.

1. *"discourse' refers to occurring instances of communication, they form linguistic units which exceed the limits of a single sentence, the discursive may help to highlight means of various methods or structural features and relations which characterise the linguistic constructions"* (Thomson, 2003).

2. *"a good working definition of a discourse is that it should be a system of statements which constructs an object"* (Parker, 1992).

3. *"discourse can refer to a group of ideas or patterned ways of thinking which can be both identified in textual and verbal communications and located in wider social structures"* (Lupton,1992).

The first of the descriptions above can be seen to have a linguistic orientation. In UK, the study of Discourse Analysis, as a discipline within applied linguistics, has been closely associated with the work of Sinclair and Coulthard (1975), whose ideas were first set forward in a classic study of classroom language. Their aim was to identify a patterning in language units of a sentence or longer which would correspond to the way units of grammar combine to form sentences. Thus, they postulated that just as, in grammar, morphemes combined to form words which combined to form clauses, which

combined to form sentences, so beyond sentence level a similar hierarchy could be identified. Thus, they suggested, *Acts* formed *Moves* which formed *Exchanges* which formed *Transactions*.

This carefully reasoned structural approach was to prove immensely useful in clarifying the nature of all kinds of professional encounters, and it remains enormously influential, at least within its parent discipline of applied linguistics (see e.g. Hoey, 2002 for further details). The extent, however, to which the approach bases itself on the study of the formal linguistic characteristics of text makes it an inappropriate methodology for the present study, where the interest is centred on what the language is used for, rather than on its formal characteristics.

Other approaches to DA that have gained increased prominence over the past three decades can be identified with descriptions 2and 3 on the previous page. The second example identifies a strand of DA that has developed within a post-structuralist framework and there has been a diverse range of studies e.g. from medicine (Foucault 1972, 1975) and cultural and literary theory (Barthes, 1974; Derrida, 1977; Shapiro, 1988). The third identified strand of DA draws more heavily on social theory e.g. the analysis of science itself (Gilbert and Mulkay, 1984), through to education (Edwards and Mercer, 1987), occupational choice (Moir, 1993) psychiatry (Harper 1999;) the social psychological concept of attitude (Potter and Wetherell, 1987) and community attitudes to mental health problems (Cowan, 1994).

The prominence of DA has not led to better understandings however. Cheek (2003) describes two main reasons for this. First, there is often poor reporting of DA studies. Many studies inform the reader of little about the underpinnings of the research,

including the way in which DA is understood by the researcher. The second problem relates to confusion about what exactly DA is, as there is a variety of approaches described and deployed as DA. The quality of discourse work is also seen to be variable within the individual disciplines (Antaki et al, 2001). Problems such as these have become synonymous with critiques of DA (Cheek, 2003).

In order to make clear at the outset and for the purpose of this study, the following descriptions have been chosen from within the framework of discursive psychology and offer one particular understanding of discourse and discourse analysis. Although the underlying principles can be taken for discourse analysis in general, these principles do not (and should not) provide or equate with a distinct set of rules or methods (methods in the traditional sense) for analysing discourse (Cheek, 2003). However, each approach to DA will provide particular guiding principals or frameworks.

By way of introduction this section has identified that there are a broad and diverse range of approaches to discourse and discourse analysis. The attention given to the study of talk and texts then has been influenced by a variety of theoretical orientations. These influences are described further below.

3.4 Historical routes and philosophical underpinnings

Having been described as being particularly sensitive to the investigation of social interaction, the main concern of any form of discourse analysis involves viewing the organisation of talk as a joint activity (Wetherell *et al*, 2001a). Other methods (both qualitative and quantitative) have tended to be more concerned with the content or

topics of talk e.g. subjects, objects or events. Discourse analysis on the other hand, views *the talk* as the topic of investigation and aims to identify what people do with language and so illuminate how talk is used to perform particular actions such as blaming or mitigating, requesting or refusing. Analysis involves an examination of how people use language to construct and make sense of the situation (Potter and Wetherell, 1987) and the analytic focus is on the discourse itself, not on internal or external 'objective' structures (Edwards and Potter, 1992).

Underpinning all forms of discourse research is the view that discourse is regarded as social action. This involves an examination of how the relationship between the *"world and the word"* is addressed in talk (Wetherell et al, 2001a) and looking at how *"language orders our perceptions and makes things happen (and is) used to construct and create social interaction and diverse social worlds"* (Potter and Wetherell,1987).

This approach to understanding language was first made possible by the work of Wittgenstein (1953) and Austin (1963). In the study of speech acts and what people do with words, these authors examined the relationship between knowledge production and language use in linguistic philosophy. Later, a broader approach to understanding language and its use developed from post-structuralism. Foucault (1972) for example, moved from looking at language in itself to looking at 'discourses'. He postulated that it is the actual discourses in use that produce knowledge and power for participants rather than simply the words used and claimed, for example, that 'madness' or 'punishment' could only have meaning *within* the discourses about them. For Foucault, discourses are both infused with power and knowledge and play a role in producing power and knowledge (Carabine, 2001 p268). Foucault was concerned about the ways in which power and knowledge were seen to regulate society (following Foucault, see van Dijk,

1984;1991; 1998; Parker, (1992); Burman and Parker, 1993). By way of example, an extract is presented below to illustrate the nature of Foucauldian discourse analysis. This extract has been taken from the work of Carabine's genealogical analysis of unmarried motherhood (2001).

> *...the disintegration of the nuclear family is the principal source of so much misery and unrest. The creation of an urban underclass, on the margins of society, but doing great damage to itself and the rest of us, is directly linked to the rapid rise of illegitimacy. The past two decades have witnessed the growth of whole communities in which the dominant family structure is the single-parent mother on welfare, whose male offspring are already immersed in criminal culture by the time they are teenagers and whose daughters are destined to follow the family tradition of unmarried mothers ...*
>
> (Extract from an article reported in the Sunday Times, 28th February 1993)

Carabine's analysis of this extract identified a number of ways in which 'lone-motherhood' is spoken about. These include notions of deviance and immorality, burden to society, threat to traditional family values and marriage, dependency and homogeneity, implying that all single mothers are viewed in similar ways. The effects of such discourses have been seen to have political and social impacts, for example, by making access to benefits more difficult or conditional, making local authorities no longer responsible for prioritising housing in the case of young single mothers and so on. The point to be made here is that discourse analysis of this kind is concerned with identifying more global and political issues and indeed, works to challenge the social

and political trends. It is less concerned with complexities involved in the joint production of the talk at the situated and local level.

Not all discourse researchers believe that this kind of 'critical' stance is always necessary however, and some consider that such approaches will limit examination and understanding of language use at the interpersonal and procedural level and thus, will neglect the constitutive nature of the social world. Other approaches or traditions that have emerged have been informed by Ethnomethodology, the study towards 'everyday sense-making' practices (e.g. Garfinkel (1967) and the discipline of Conversation Analysis (CA), defined as the study of 'talk-in-interaction' (e.g. Schegloff, 1992) or as *"an explication of the ways in which conversationalists maintain an interactional social order"* (ten Have, 1999 p41). Whilst a CA approach to the analysis of 'talk-in-interaction' aims to identify the structural organisation and order of an interaction this approach does not concern itself with the rhetorical features of language use.

The section above has drawn attention to the fact that there are a number of ways to understand 'discourse' and there are different theoretical approaches to discourse analysis which, in turn impact upon how it is conducted. The next section will describe in further detail the approach taken in the present study.

3.5 Discursive psychology

The approach deemed most appropriate for this study developed from the field of discursive psychology. This discipline holds the view that language use or 'talk' is varied and contradictory and is used to perform particular functions and thus talk is

'*action-orientated*' (Edwards and Potter, 1992). This can be seen to contrast with other DA approaches such as Critical Discourse Analysis, where analysts can be seen to take a more global view of language use and consider 'discourses' as underpinning the construction and maintenance of systems of power and ideology. To adopt a broad-brushed, critical approach for the present study would not provide specific knowledge as to how treatment decisions are accomplished in the consultation or how patient involvement in decisions is generated at the local level. There already exists a significant body of literature that provides a particular view of the medical setting from more post-structural or critical discourse analysis (e.g. Foucault, 1975).

Whilst more critical approaches such as these offer significant contributions to particular understandings of the medical consultation they are not concerned with the individual variation between different participants intent on sharing treatment decisions. This is not to say that concerns with power are to be ignored but the aim of the study is to explore how the SDM consultation is constructed, how decisions are accomplished through a process of joint production and how decisions are constructed locally and in which, are thus, emergent properties of the interaction. Power in this case, relates to the ways the agenda, trajectory and conversational space are dealt with.

A discourse analytic approach based on the model from discursive psychology offers the present study a more fruitful approach than the traditional cognitive approaches used in the study of the doctor-patient interaction. This approach provides the opportunity to re-conceptualise the traditional questions asked of, and the investigation into the nature of sharing treatment decisions. As a consequence, some of the barriers to this particular style of medical decision-making may be addressed. Rather than examining the

interpersonal and cognitive aspects of the interaction the discourse or 'talk' of the consultation can be examined to illuminate both what is said and what is done with the talk (i.e. how the talk is seen to function). This view, that language use should be seen as a vehicle for action, provides one basis for the construction of reality and as such, suggests the notion that it is not possible to view the world in isolation from discursive practices.

In order to identify information and knowledge that encapsulate the nature of shared decision-making it is necessary to use a method that can address more specifically the ways discursive activities construct and order the reality of SDM in particular ways. Thus, the discourse analytic approach deemed most suitable for this study is based on the Discursive Action Model (Edwards and Potter, 1992), as it provides both a theoretically informed conceptual scheme and an analytic method to assist in the identification of discursive features particular to the negotiation and sharing of treatment decisions. The model is described in detail below.

3.6 The discursive action model

By examining the interaction using the DAM framework the researcher can identify the key features of participants' discursive practices that serve to accomplish SDM. This involves addressing three interrelated features of the interaction. The model below has been taken from Edwards and Potter (1992 p154).

Action

1. The focus is on action, not cognition.
2. Remembering and attribution become, operationally, reportings (and accounts, descriptions, formulations, versions and so on) and the inferences that they make available.
3. Reportings are situated in activity sequence such as those involving invitation refusals, blamings and defences.

Fact and Interest

4. There is a dilemma of stake and interest, which is often managed by doing attribution via reports.
5. Reports are therefore constructed and displayed *as* factual by way of a variety of discursive techniques.
6. Reports are rhetorically organized to undermine alternatives.

Accountability

7. Reports attend to the accountability in the reported events.
8. Reports attend to the accountability of the current speaker's action, including those done in reporting.
9. The latter two concerns are often related, such that 7 is deployed for 8 and 8 is deployed for 7.

First, this model is concerned with identifying the 'action-orientation' of talk, i.e. what participants are doing with their talk (e.g. remembering, attribution, explaining and justifying). Three questions can be asked at this stage. How are these activities practically accomplished or constructed? What is it that participants are doing with their talk? How do participants designate causal explanation to events or claims within their descriptions and accounts to prevent undermining? The second concern for DAM is with the construction of fact and interest. Analysis involves identifying how people construct and manage accounts to make them appear solid and factual. This involves looking at how participants view and attend to the accounts of others as being motivated by self-interest. This entails locating and describing the discursive strategies (e.g. fact construction and stake inoculation) that are used to counter and resist claims on the grounds of stake and interest. The third concern this model attends to is an interest with the construction of accountability. Accountability is viewed as a discursive practice and the concern for the analyst is in how participants use descriptions and reports in order to make certain inferences available to the recipient (e.g. causal attribution) and also in how reports and claims are constructed to address issues of agency.

This approach to analysis will help illuminate the activities within the doctor's and patient's talk by enabling exploration of the discursive practices involved in the decision-making context. Applying this model to the extracts from consultations will enable them to be understood as a joint production. New information and knowledge on how SDM is accomplished discursively will be made available as DAM offers a framework for unpicking the assumptions (common sense and otherwise) underpinning SDM. The final section of this chapter outlines the research questions.

3.7 Research questions

Further detail on the process of analysis is provided in Chapter 4. Owing to the analytic approach taken to this study the research questions were not specified at the end of the background literature review. It is more appropriate to identify them after describing the analytic method chosen for this study. The research aims are summarised below and the specific research questions are also provided here.

The broad aim of this study is to examine the joint production of shared treatment decisions in General Practice. To do this it is necessary to identify and describe the social actions that the participants' talk is seen to accomplish within the local setting of the consultation as well as to examine the referential/representational nature of the talk. In order to bridge the gap between theory and practice identified in Chapter 2, it is necessary to ask the following broad questions: *How* are shared decisions actually accomplished as a discursive event; *How* do participants' conversational practices encourage (or discourage) active participation and involvement from patients; *What* are the rhetorical strategies and resources that are deployed when accomplishing treatment decisions; *What* are the actions of these on the interaction and the implications for shared decision-making as a style of doctor-patient interaction? The DAM framework has provided an opportunity to explore these questions by using a theoretical framework to assist the analysis of 'best practice' examples of shared decision-making consultations. The specific research questions are:

1. What particular discursive strategies do participants utilise when negotiating treatment decisions?
2. What social actions are accomplished with the participants' 'talk'?
3. How is participants' talk constructed to accomplish treatment decisions?

The next chapter describes the data collection procedures and the process of analysis.

CHAPTER FOUR

Methodology

4.1 Introduction

As has been shown in the previous chapter recent work on the shared decision-making (SDM) approach to healthcare provides a substantive body of literature. This has identified the philosophies underpinning this approach to treatment decision-making and has informed on how this knowledge is being used to influence and change consultation styles. The review also outlined what are perceived to be particular gaps in the existing knowledge and in particular, gaps resulting from cognitive based research that has tended to examine one half of the interaction in isolation from the other. The primary methodology used in this study was presented in Chapter 3. This chapter reports on the secondary methodologies used in the data collection process and is divided into two sections.

The first section begins by providing details of the research site and participant recruitment before it describes the two-stage process that was used as a filter to identify the consultations for analysis. This includes details of the questionnaire and interview design. Following this, details of the pilot and early data gathering process are presented and the subsequent refinements made to the final data collection procedure are detailed.

The second section discusses the approach taken to and the activity involved in data analysis. This includes a description of the process involved in data production e.g. transcription, extract selection and approach to analysis. The final part

of this section addresses data management. The steps involved in editing and storing raw audio data are outlined.

4.2 Section 1 – Study design

This section provides details of the research setting, participant recruitment and the data collection process. It continues by describing the rationale for the methods used to collect a sample of consultations that were deemed to be examples of best practice (of shared decisions). Details of the pilot and the subsequent refinements made to the data collecting process are also outlined.

4.3 Research site

4.3.1 Ethical approval

Tayside Ethics Committee granted ethical approval, Reference number 78/01.

4.3.2 General practice

In the UK a large proportion of all illness episodes are managed within an established system of primary care, i.e. general practice, (Pendleton et al, 1984). Although it is very likely that medical decision making over other health settings will vary (for example, decision making for patients with terminal illness may be much more informed by the patient than situations or conditions where an immediate response is required such as first aid) there may be more scope to practise a shared approach to health care in general

practice than is possible in other settings. In addition, GPs may have embraced more patient-centred approaches to healthcare than in secondary care.

As funding for the study had been secured, the location had been decided upon. Tayside provided a suitably mixed region as it is set within a relatively small geographic area and facilitates easy access to rural, urban, and postgraduate training based general practices. The locally run training course at the Department of General Practice was also helpful in locating suitably experienced GPs. Here, the 'Therapeutic Alliance Model' has been used to assist clinicians in learning how to achieve shared goals and decisions with patients in medicine taking behaviour (Dowell and Hudson, 1997). Thus, there is a higher probability that these clinicians will possess the skills required for SDM[9].

4.3.3 General practitioner recruitment procedure

In order to collect SDM consultations as efficiently as possible, the sample was enriched by recruiting practitioners who had experience with the 'Therapeutic Alliance Model' described above. The course trainer initially approached the GPs and informed them of the present study. The researcher informally approached other practising GPs, involved in medical teaching or actively engaged in Health Service Research (HSR) elsewhere in Tayside. The aim was to recruit between six and eight GPs. The next step involved contacting each one formally, with further details of the study. Six out of eight GPs approached agreed to participate in the study. Participating practices included five General Practices within Tayside. Demographic information is provided in Table 1 in the Appendix.

[9] Participating GPs received four days training on the process of SDM.

GPs were visited at their practice to ensure their interest in the study discuss and practical arrangements. Copies of all the materials required for data collection were provided at this time (e.g. patient information, draft of GP letter, and consent forms). GPs were invited to make changes to their patient invitation letter if they wanted to do so. They were also informed at this time that their practice would be reimbursed for their time and these costs would be met by TAYREN, the local primary care research network. As the consultations were to be recorded, GPs were given a demonstration of the minidisk and invited to practise using it. During this visit the practical arrangements for data collection were made in consultation with the practice manager.

4.3.4 Patient recruitment

Patients were invited to participate by letter. Practice staff posted letters out at least three days in advance of their appointment[10]. Each letter contained an invitation to participate from the GP, a copy of the background to the study and a patient information sheet detailing the requirements of participation. Copies of all the materials are contained in the Appendix.

Patients unable to provide informed consent and those less than 18 years of age were excluded from the study. There was no upper age limit, thus the range ensured inclusion of most adults with a wide range of conditions so findings would be relevant to a wide range of general practice patient care.

[10] As most general practices operate a system whereby patients can book an appointment on the day it could not always be assured that all potential participants received information about the study by post.

4.4 Pilot

The present author piloted the data collection process in its entirety at a separate inner city practice (8/6/2001). This provided the opportunity to identify and address any problems with the collection procedure. Field notes were recorded during the pilot and the data collection phase. After reflection it was apparent that some refinements to the collection process were required. After the pilot and some subsequent minor refinements the data collection procedure was found to be efficient and successful. Further details on the data collection procedure, the difficulties encountered and the ways in which they were resolved are presented below.

4.5 Procedure

4.5.1 Informed consent

The researcher approached patients after reporting their arrival to the practice receptionist and/or in the patients waiting area. Before seeing the doctor, patients were asked to sign two consent forms, the standard one required by the local ethics committee and the one developed specifically for the present study. Both forms asked for consent to record the consultation and permission for the information in the recorded consultation to be used for research into how doctors and patients reach treatment decisions. The latter form requested that patients provided consent again after the consultation. Following the recommendations set out by the Royal College of General practice, it was felt that by requesting consent again provided patients with the opportunity to change their minds or ask for further information about the study. In addition, throughout all stages of the data gathering patients were reminded they could

change their minds about their participation at anytime, and without having to give a reason. This option was also written on the patient information sheet. Further, as part of their own good practice, the GPs also checked consent with the patient before recording the consultation. The difficulties encountered at this stage of the procedure are reported below.

4.5.2 Time constraints

The first difficulty related to time constraints. In order to prevent the doctor from recording consultations without the patient's consent it was necessary to request permission from patients prior to them entering the consulting room. In addition, to avoid holding patients' up after seeing the doctor, it was necessary to present the patients' with the questionnaire as soon as they left the consulting room. At times this process was rushed and less than satisfactory for a number of reasons. For example, in spite of most patients' receiving an information sheet through the post many wanted to learn more about the study. It was also apparent that some patients were unclear about their participatory role, even although they continued to express a willingness to be involved. It was noted at this time that some patients had not read the patient information sheet properly (if at all). It was decided that making the information sheet available again at the reception would save time, and also enable patients to participate more actively. Extra time was given, whenever necessary, to ensure these issues were resolved by giving patients the opportunity to discuss concerns or ask questions. In some instances patients were not invited to participate however, as it was not always possible to obtain consent, in advance of seeing the doctor. On these occasions, it was regarded that these patients were not fully informed.

As data collection progressed, with help from experienced practice staff, it was apparent that patients' had a greater understanding about the study and their subsequent participation in it. It had become evident that the information provided to patients in the waiting area, prior to their consultation, had been listened to and understood by others. As a result patients had gained a clearer understanding by the time they were approached for consent by the researcher. This helped to reduce the number of questions and requests for further information significantly, and thus, more patients' were appropriately informed before seeing the doctor.

4.5.3 Refusals

As would be expected the nature of a patient's illness might influence the decision to participate in the study. Patients who were feeling very unwell or were seeing the doctor for more sensitive concerns were possibly less likely to want to participate. In all, 110 patients agreed to participate in the study and 55 patients refused. Patients were not asked to give reasons but the numbers of refusals for each doctor were recorded (Table 1, Appendix).

4.5.4 Information in advance

Not all appointments can be made in advance. This meant that patients booking on the day did not have as much time to consider their involvement. Some thought was given to this problem and after discussion with other GPs and supervisors it was felt that there

was no way round this as it would be likely to occur in most practices. However, from an ethical perspective if there was any doubt as to a patient's ability to give informed consent and depending on the individual patient's inclination to participate, the decision whether or not to recruit onto the study would need to be left to my discretion. For example, on one occasion it would have been improper to request consent from a patient as it was clear that the patient was not in a position to fully understand the implications of his participation, and as a result his consent could not be regarded as being informed. This situation was addressed by providing the patient with an apology for me not having enough time to explain things properly. The patient was informed that he would not be required to complete the questionnaire because of this. After his consultation however, he said that he had spoken to the doctor and was quite happy to have his consultation tape-recorded and asked for a questionnaire. Whilst I remained uncertain about the patient's ability to give informed consent he was given a questionnaire to complete but the data was not used. I felt my clinical background provided the necessary skills and experience to enable me to make this decision (having worked as a psychiatric nurse for more than 20 years).

4.6 Data collection

This section describes the two phases of data collection. It begins by providing the rationale and the theoretical background to the questionnaire used as the first level of sampling. It then describes the practical activities involved in the administration of this, and is followed with the results of the questionnaire. The detail on the second level of sampling, the interview process, concludes this section.

4.6.1 Sampling

Whilst the central methodology of this study is qualitative, quantitative methods were helpful in identifying and selecting a sample of SDM consultations. As qualitative analysis tends to be extremely time-consuming the researcher has to be selective as an overwhelming amount of surplus material can be collected. A questionnaire was used to, first, identify shared-decision consultations, and secondly, identify best practice examples.

4.6.2 Rationale for questionnaire

The first phase of the sampling process was designed to filter out consultations where other forms of decision-making were practised. To examine all consultations in this thesis would have proved inefficient and contrary to the research objective. The aim was to target only those consultations where SDM was perceived by the patient to have occurred. This way, patient's views on SDM could be introduced. Utilising a questionnaire provided a practical and efficient sampling technique and also offered a means of focusing on the richest data.

4.6.3 COMRADE

The questionnaire used as the sampling tool was COMRADE. This instrument, developed by Edwards *et al* between 2001-2002, was specifically chosen over other outcome measures of patient satisfaction because it addressed the topic of decision

making more directly. Therefore, it was expected to be sensitive to particular characteristics of the decision-making process, which may be unique to the SDM context. As this questionnaire had not been published at the time of data collection, and thus not in the public domain, the background to its development is provided below.

COMRADE was developed as a tool to evaluate the effectiveness of decision- making and risk communication in consultations. Key informant interviews were used to identify the stages and competences required for shared decision-making. From this 43 items were identified initially. After piloting with 960 patients (with diagnoses of atrial fibrillation, prostatism, menorrhagia or menopausal symptoms) factor analysis was used to revise the instrument. Subsequently, the number of items was reduced to 23. This comprised 3 subscales: communication; satisfaction with decisions; and support in decision-making. Duplicate questions were used to analyse internal reliability and it was validated by reference to patient interviews, thus it had been validated as a patient-based outcome measure. Following further refinement the subscale 'support in the decision' was removed and as a result, these changes had to be incorporated within the present study to maintain reliability as well as maximise its use. Details of these changes are given below.

4.6.4 Refinements to questionnaire

Three refinements were made to the questionnaire during the data collection process. First, as mentioned above, the questionnaire had undergone some developmental changes. This meant that the questionnaire scores collected at the beginning of data collection were originally based on three subscales. As COMRADE ultimately

comprised two subscales, this factor was taken into consideration and thus, the early questionnaires were re-scored at a later date. Second, the questionnaire had originally been presented on both sides of a single sheet of A4 paper but some patients had failed to notice both sides. Although it was a simple task to remind the patients or check upon completion the layout was changed from A4 to an A5 booklet. The third refinement was made by removing the words *'shared decision-making'* from the information provided on the first page of the questionnaire. These words were replaced with *'a study looking at how decisions are made between doctors and patients'*. It was felt that the original wording might influence the respondents' answers and/or be less 'user friendly'. It was however, a requirement of the Tayside Ethics Committee that the study title be included on their standard consent form therefore, participants were aware that it was 'shared' decisions that this study was addressing.

4.6.5 Administration of COMRADE

COMRADE was administered to patients after they had consulted with their doctor. The practice staff had provided a room where patients were given time and privacy to complete the questionnaire. Patients were given instructions on how to complete the questionnaire and then were left undisturbed. On two or three occasions, and at the patient's request, the questions and the set of possible responses were read out loud and I recorded the patients' responses. A copy of the questionnaire is contained in the Appendix.

The use of the questionnaire achieved the desired success, i.e. it was able to identify consultations deemed to be examples of best practice of shared decision-making. The

results from COMRADE are presented in Table5 below (Further details on individual GP scores are contained in tables 2-7 in the Appendix).

4.6.6 COMRADE results

Table 5

Descriptive data for the two factors of COMRADE for Gwent and Tayside

	Communication		Confidence	
	Gwent study	Tayside study	Gwent study	Tayside study
Mean	**66.7**	**88.6**	**73.4**	**90.7**
SD	**14.82**	**12.54**	**9.70**	**12.50**
Minimum	1.8	48	29.3	48
Maximum	93.8	100	100	100
N	579	110	579	110

The results from the Gwent study by Edwards et al (2002) showed the 2 sub-scales of satisfaction (with communication) and confidence (in the decision) had been scored independently. The same procedure was repeated for the Tayside study. The overall means for Gwent and Tayside were 70% and 90% respectively. Bearing in mind that COMRADE was validated for medical consultations in the UK its administration in the Gwent study will have included paternalistic, shared and informed decision-making styles. Since the medical consultations in the present study were more likely to be based on the shared decision model, (i.e. GPs were trained in the Therapeutic Alliance Model and knew shared decisions were expected) the difference between the means is possibly a reflection of this. Thus, the scores above the mean for each GP were used to identify

examples of their best practice of SDM. As 33 questionnaires scored below the mean for each GP these were subsequently excluded from the dataset.

COMRADE identified 77 suitable consultations. Descriptive data for COMRADE for the 6 GPs is shown in table 1 of the Appendix. Further purposive sampling ensured inclusion of a wide range of treatment conditions. This strategy avoided an over-collection of samples from the same treatment category. Categories included referral for investigation and preventative treatments, symptomatic and asymptomatic conditions and mental health. Details of treatment categories and distributions are contained in Table 8 in the Appendix.

4.7 Second level sampling and interviews

Semi-structured, in-depth interviews were used as a second filter to identify the consultations for discourse analysis and as a way to ensure those selected were considered by patients to be genuine examples of SDM. The interview schedule was constructed to assist in the exploration of patients' views on the decision reached and the decision-making process. Questions were designed to encourage patients to describe and discuss their views about their role in the decision-making process. The schedule was also loosely constructed around the stages and competences of shared decision-making described by Elwyn and Charles (2001). Refinements to the schedule were informed as data collection progressed. A copy of the final schedule is contained in the Appendix. During interview the patients' previously recorded consultation was played back to them, in order to stimulate recall.

4.7.1 Interview selection

Patients had been asked in the consent form if they were agreeable to being contacted at a later date with a view to being interviewed. This meant that information was available to ensure that patients who had declined were not approached again later. After scoring the questionnaire and identifying a list of potential interviewees on this basis, their recorded consultations were checked to ensure a relevant decision had been reached before making contact with them[11].

Patients were provided with information about the purpose of the interview over the phone (this practice was repeated again before the interview began). They were also told when arranging the interview that it would take around an hour. After arranging each interview a copy of the consultation was prepared so this could be played back during the interview to help the patient remember. All participants that were approached agreed to be interviewed and have allowed the interview to be included in the study. All interviews were carried out within four days of the consultation to minimise loss of recall (Cromarty, 1996).

4.7.2 Interview training

The interview process was also piloted. This process revealed that the interview schedule needed some refinement and that some interview skills training would help me

[11] As the study and analysis progressed however, I became aware of how my own cognitive perceptions influenced the way I was listening to and heard the consultation. It then became more apparent that most of the decisions were not 'shared'. Rather, their rhetorical constructions used during 'option negotiation' had the action/effect of inviting consensus.

to develop better interviewing skills. The schedule was refined (several times) and an interview skills workshop was arranged to help with my training. This session was designed to help other novice researchers improve on their skills by reflecting on their interviewing experiences and it also facilitated discussion over interview material 'data that had posed concerns (for example, identifying difficult moments such as exploring the problems arising from asking closed questions). Role-play was also used to help practice and develop the necessary skills. The group reflected on each example and made suggestions on improvement. This training helped to prepare for the interview phase.

4.7.3 Interview procedure

Consent was again sought from participants before interviews were recorded on minidisk. At the beginning of each interview participants were reminded of the study and the purpose of the interview was explained. Each patient was given the same information. This information can be found at the beginning of the interview schedule contained in the Appendix. Interview topics were discussed as they were spontaneously brought up by patients to allow conversation to progress as naturally as possible. However, if any topics did not arise then they were introduced formally.

Most participants appeared to enjoy being able to discuss their views and seemed pleased to have the opportunity to do this. Generally, participants had plenty to say and were only interrupted for the purposes of clarification or elaboration. At the end of the interview the participants were asked if they were still happy for information provided in the consultation and the interview to be used in the study. They were also asked

directly if they felt that their consultations were good examples of sharing decisions. Before ending the interview the schedule was rechecked to ensure all topics had been covered before inviting patients to comment on any aspects they felt had been missed out. In addition, this ensured that patients were given a genuine opportunity to be involved in the research.

During the initial interviews, patients were asked to identify when/where they saw/heard significant events taking place in their consultation. Although encouraged to express their views at length, it was observed that patients often struggled and appeared uncomfortable with some of the questions. This may have been the result of being asked vague questions. However, more direct questions (open and closed) did not yield further information. It was decided that for the remainder of data collection patients should no longer be asked to identify 'events' as it was clear this was a difficult task and possibly a consequence of inexperience in participating in research or in being invited to give their opinion.

4.7.4 Interview data

After the interviews had been undertaken consultations from patients, who had continued to express a high degree of satisfaction with their consultation, and who had stated that the treatment decisions had been shared, were selected for analysis. These interviews were evaluated using a checkbox to identify when the stages and competences of SDM were apparent during the interview. The aim was to establish whether or not SDM was actually taking place. Thirty-four interviews were carried out. Four were excluded from analysis (Details are contained in Tables 2-7 in the Appendix).

COMRADE, with support from the interviews, had identified suitable cases for analysis. In all, thirty consultations were transcribed. This process will be described in detail in the next section. To conclude this section, Figure ii. presents a flow chart providing a summary of the sampling process below.

4.7.5 Figure ii. Flowchart summarising the sampling process.

Data Collection Process

Sampling - Phase 1

110 consultations were recorded on minidisk

↓

COMRADE scores of mean or above identified 77 consultations as potential data

↓

COMRADE scores below the mean excluded 33 consultations as unsuitable

Sampling - Phase 2

34 Interviews were recorded on minidisk

↓

4 interviews were excluded as unsuitable

↓

30 interviews used to select corresponding consultations

↓

30 consultations were ultimately transcribed and used for data analysis

4.8 Section two - data analysis

Having established and positioned the analytic approach in terms of the DAM framework in Chapter 3, this section begins by describing the first step of analysis. This is concerned with the 'reconstruction' of the recorded consultation material into text (transcripts) to enable detailed and proper analysis.

4.8.1 Transcription

Turning talk into text is possibly the most labour intensive and time consuming activity involved in discourse analytic research. This highlights a concern for both the researcher and the funding body. Depending on the detail required estimates of how long it takes to transcribe 1 hour of recorded material range from about four hours for the simplest transcription of an audio-recording to more than twenty hours for detailed transcription (Wetherell, 2001b p29).

From a theoretical position, when deciding on the degree of transcription the researcher has already taken the first steps of analysis (e.g. Ochs, 1979). It is not simply a mechanical process, and according to Potter (1996) the nature of transcription is theoretically oriented and transcribed detail *"is an intrinsic and essential part of the interaction" (p9)*. This further warrants the argument for researchers to do at least some of the transcribing as opposed to for example, audio-typists. It is also important to recognise that the particular level of detail will influence analysis. For example, tensions exist relating to aspects of gender. The researcher has to decide if gender is relevant

within the interaction and if it should be made apparent to the reader. For the present study the issue of gender was considered and it was decided that gender identity markers were to be omitted wherever possible. This is not to say however, that gender was not relevant but for the particular aims of this study gender was not a prime concern. There are already a significant number of studies that have identified gender as the topic of concern within medicine (see for example, Cahil, 2001; Speer, 2002; Ehrlich, 2002; Peace, 2003; Kaiser, 2002).

As is typically the case, trade-offs were necessary between producing good quality transcripts that would allow for the fine-grained analysis required for this study and readability. A further factor considered before deciding on the transcript detail was in acknowledging that greater detail does not necessarily generate greater analysis or analytic conclusions. With these factors in mind the raw audio data was used alongside the transcripts during later analysis. This allowed for the transcripts to be further edited and thus made detailed enough to highlight particular features without making them too difficult to read. Whilst discourse analysts will become accustomed to extremely detailed transcripts and learn to read these with relative ease it is without doubt that a good deal of practice is required. It is proposed that the level of transcription in this study provides a relatively easy read for readers from within the medical discipline. Therefore, the transcribed sequences of talk should not act as a barrier for healthcare professionals.

The next section outlines the process of transcription. Two sequences of the same talk are provided below to illustrate the kinds of detail or information that different levels of transcription can produce or make available in talk or texts. The second example

highlights aspects of the conversation that is missing from the first, verbatim example, and provides the rationale for the level of transcription required for the present study.

Audio-recorded material is not generally regarded as data for discourse analysis without the process of further selection through transcription. In effect, the transcription process can be used to provide various kinds of data depending on the analytic focus. By way of example, a sequence of talk from a consultation is presented below to illustrate the level of transcription normally deemed sufficient for more traditional qualitative analyses (e.g. content analysis or grounded theory approaches).

4.8.2 Example 1

Dr: What they've said is what it's not. I think when you get
a pain in your chest they want to make sure it's not your heart.
Pt: They've done that.
Dr: They're saying it's not your heart
Pt: My heart's a strong as an ox
Dr: There maybe is sometimes a tendency to blame panic attacks if you can't get physical disease that would fit nicely with what's wrong with you. But off the top of my head that sort of thing sounds like it could be almost like a migraine type thing.
Pt: But I don't get headaches.
Dr: You don't. You can get what's called hemiplegic migraine where basically the side of your body goes paralysed for a few minutes or an hour or so. You don't have to have. It sounds weird but you don't have to have headaches with migraine. It could be something like that.
Pt: But where do I get the pain in my chest then?
Dr: Okay, you got me there. I can't think of a disease that would cause both things.

Example 1 follows a more basic form of verbatim text presentation. Readers will attend to what was spoken by applying punctuation rules. The aim of this form of transcription is to represent the 'gist' or what words were said using verbatim reporting. This detail is usually seen as adequate for approaches concerned with the identification of themes or

categories that are regarded as representative of dispositional characteristics (e.g. personality). The example above can be seen to re-present the general picture of what was said and is easy to read and straightforward.

It can also be viewed as having been tidied up to facilitate ease of reading for example, no inclusion of tone or hesitations. It does not, however, provide enough information for those interested in examining the features of interaction that the present study wishes to examine. In studies of medical interactions it does not necessarily follow that the interest for the analyst is with the medical problem discussed or even the doctor-patient relationship. Coupland and Coupland (1998) have shown that medical consultations can be analysed to show different features and patterns within this form of interaction. Their approach required a level of transcription that provided the details necessary to examine the nature of the interaction in more depth. As the present study is concerned with the discursive activities involved in the interaction it was necessary to generate data that could attend to this. The second example presents the same sequence of talk but with more detailed transcription. As will be shown, the extra detail made available provides more information about the nature of the interaction which is critical for fine-grained analysis.

4.8.3 Example 2

1. (.5) I mean (.) you know (.) what they (.5) it's (.)
2. it's (.5) what they've said is what it's not (.5) I think (.) you
3. know (.5) I think when you get a pain in your chest they want to
4. make sure its not your heart I think that (.) (you know =)
5. Pt: (=They've done that)
6. Dr: (=they're saying it's not your heart =)
7. Pt: (=they're saying)
8. Dr: (=Yeah Yeah, ther:)
9. Pt: (=I've got a ...)

10. Dr: (=the-)
11. Pt: (My heart's as)
12. Dr: (ther-)
13. Pt: =a strong as an ox.
14. Dr: There maybe is sometimes a tendency to blame panic attacks if
15. you can't get physical disease that would fit nicely with what's wrong
16. with you (.) Ahm (.5) but off the to:p of my head tha:t sort of thing
17. sounds like it could be almost like a mi:graine type thing (.5) you don't
18. (ne::cess:)
19. Pt: (=But I don't get headaches.)
20. Dr: (You don't) (.5) I mean you ca:n get what's called hemi:plegic
21. migraine where basically the side of your body goes paralysed for a few
22. minutes or an hour or so (.5) you don't ha:ve to have:
23. Pt: (=Mhmm)
24. Dr: it sou:nds weird but you don't ha:ve to have headaches with
25. migraine (.) I mean, it c:ould be something like th:at.
26. Pt: well wh:ere do I get the pai:n in my che:st then
27. Dr: .hh okay, (you got me the:re=)
28. Pt: (laughter) he:e hee he he he)
29. Dr: =but you know I can't think of a disease that would cause both
30. things (1.5) is what I'm saying.

The first sequence showed transcription at a more conventional orthographic level. This second example provides considerably more information about the interaction and can be seen to help readers 'hear' rather than simply 'read' the interaction. The overlaps in speech, the pauses and hesitations and the inclusion of non-discursive activities such as laughter serve to illuminate the minutiae of the conversation. It should also be stated that by including this detail, the researcher has already decided that these features have some bearing upon the interaction. That is, they are significant upon the interaction whether or not they have a theoretical basis at this point. Nonetheless, Example 2 is a lot 'muddier' than Example 1 and readers are likely to find it more difficult to follow because it deviates from normal text presentation styles. The readability dilemma is a concern for both the researcher and the audience. Detailed transcription can make the extract more 'hearable' and therefore will aid analysis but at a potential cost of rendering the engagement with transcript difficult. Still, it is apparent that detail provides the reader with extra information that would normally be absent in a simple

verbatim transcription. Detail also provides the sense of evidential utility as a counter to undermine potential criticisms relating to an inattention to contextual features. Thus, the basic level of transcription seen in Example 1 is not deemed as detailed enough for the present study.

4.8.4 Transcription Notation

In this study, transcripts from texts are presented in two different ways. For quotations in the main body of the text, a relatively narrow, detailed transcription is used, based on a version derived by Gail Jefferson, as for example, reported in Atkinson and Heritage (1984: ix-xvi). In the interests of readability, and as a reflection of the general rule that text should never be transcribed in more detail than the purpose demands, full transcripts in the Appendix are given a much broader transcription with substantially less detail. Here, the focus is on what was said rather than on how it was said. The conventions used for these transcripts are contained alongside in the Appendix and follow the notation of Potter and Wetherell (1992). This was the standard to which the data was originally transcribed, with the greater level of detail being reserved for quotations as this offered a more detailed level of scrutiny. In the main text, the following transcription conventions are used:

- Pseudonyms were used in place of all names except for the researcher's name.
- Lines are numbered (1at start of extract)
- Where sequences of talk are omitted from an extract this is reported.
- Unclear speech is reported as such.
- Where talk is louder or quieter than the surrounding speech this is reported.

- In-breaths and out-breaths are reported in parenthesis.
- (.) A dot enclosed in a bracket indicates a perceptible pause in the talk of less than two tenths of a second.
- (.5) The number in brackets indicates a time gap in seconds. Timing of pause lengths was considered to contribute to this analysis and as data had been recorded on minidisk the lengths of pauses were immediately available from the raw audio data.
- : A colon at the end of words indicates an abrupt stopping by the speaker another speaker and marks out a restrained utterance.
- : A colon in the middle of a word indicates intonation or emphasis by the speaker. More than one colon present within a word indicates greater emphasis.
- ( ) Overlapping talk is marked with parenthesis.

Before concluding the section on transcription, one final point to note is whatever level of transcription is carried out, all transcripts are in fact a re-construction of the events (in this case, the consultation) and built from whatever the researcher has selected from the materials available and these include the researcher's worldview.

4.8.5 Formatting raw data

To include the raw data alongside the transcripts I used a specialist software package (Soundforge) that enabled the audio data to be compressed into files that could be stored and combined with the qualitative software programme (ATLASti) on the hard drive. The potential benefits from listening to the consultation whilst reading the transcript

promised a more efficient analysis. Having audio data to hand also offers a form of evidential utility that may be unavailable in transcripts. As stated, the inclusion of inflection and intonation is difficult and time-consuming and could result in a reduction in readability because of the additional symbols needed to make these features apparent. Using the raw audio data alongside paper transcripts made the initial transcription and later editing more efficient and practical. This also helped to provide a higher standard of analysis.

4.8.6 Data management

Unlike some other qualitative research methods, discourse analysis does not reduce data into themes or categories but instead data tends to be expanded through analysis. Therefore, a great deal of textual material was produced and the software programme, ATLASti, was used to assist in both in the storage of this material and the preliminary coding for discourse analysis.

4.9 Method of analysis

4.9.1 Preliminary analysis and coding

It is essential to remember at this point that the consultations selected for detailed analysis were chosen because they were rated very highly by the patients from a scale used to measure SDM. Thus, it was reasonable to conclude from the high COMRADE scores that participants were likely to believe they were accomplishing SDM.

The first stage involved getting familiar with the data. The basic transcripts were read and re-read many times and notes were made alongside. The next activity involved reviewing the notes and constructing summaries of the features and patterns identified. After compiling a list of features to search for from the framework for SDM (e.g. references to choices and decisions and other terms that could be used to describe concerns with the competences required for sharing) the data was searched systematically for these features. Once the particular themes or features were identified, the amount of material was significantly reduced and made more manageable by using ATLASti to identify sequences of talk for detailed analysis. The extracts were initially filed as separate documents in 'thematic' folders. However, it must be stated that the difference between coding in discourse analysis and other qualitative analyse is that coding here is not the actual start of the analytic process per se, rather, it is more of a sorting process (Wetherell, 2001b p39).

After initial coding had helped to identify a range of potential analytic themes, further detailed transcription was required at this point. This was made easier by checking the raw data alongside the transcripts. This process also helped to identify features of the talk that were not apparent on the first few readings and also some of the non-discursive features of the interactions.

4.9.2 Rationale for extract selection

As the coding categories must obviously be crucially related to the research questions of interest (Potter and Wetherell, 1987) initially consultations had been examined to search

for 'evidence' of shared decision-making. A content analysis approach was used to identify the presence of the competences claimed to be required for the SDM approach.

4.9.3 Content analysis

A checklist was constructed with tick boxes to enable a systematic content examination of the whole consultation. Each consultation was evaluated in this way. However, it should be stated that subsequent extract selection for analysis was not performed on the basis of the numbers of competences present. The aim was to provide a means of extracting manageable sequences of talk from which 'recognisable' features of SDM were apparent. The point to note is that as the goal of content analysis and initial extract selection was pragmatic preliminary coding was underpinned by a set of assumptions relating to SDM (and which would be contrary to the philosophical underpinnings of discourse analysis). This meant that the rhetorical embedding of claims and descriptions was ignored at this point. The aim of sample selection was to extract sequences of talk (from at times, long and detailed interactions) that included features of SDM but the analytic approach was to consider the discursive activities at play within the extracts. Further concern with the nature of SDM was set aside to enable proper discursive analysis.

As discourse analysis allows us to look at the detail of both the content and the form of the talk analysts have to set aside concerns with pre-existing cognitive or psychological assumptions underlying many of the alternative approaches available to study talk (for example, Grounded Theory or Content or Thematic analysis). In other words analysis does not concern itself with underlying motives the participants may or may not have.

Therefore, addressing the consultation in discursive terms means that selections of talk by definition must be regarded as only part of the whole, and any individual meaning from utterances are of limited significance if studied in isolation. This is not to say however, that these concerns are set-aside in discursive analysis. Transcribed examples of the original materials are presented alongside their interpretations. This allows readers and reviewers to judge the adequacy of claims. Transcripts of the complete consultations are available in the Appendix. This way, the consultation remains available for readers when assessing the validity of the analytic findings. In addition, some extracts were considerably lengthier when decisions took longer to negotiate. This allowed the bigger picture to be in view wherever necessary to support the analytic claims.

For discourse analysts the aim is not to make claims for generalisability of analytic conclusions as is often expected or required with other qualitative analyses. This being said, the likelihood is that analytic conclusions will be generalisable to SDM consultations in primary care. For these reasons analyses also have to include other 'features' involved in the joint production of decision-making. Extract identifiers include the number of the doctor, the patient's initials and also indicates patient sex. Ultimately 22 extracts were used for intensive analysis. On some occasions extracts were taken from different parts of the consultation. On these occasions this is indicated in brackets in the extract identifier.

4.10 Analytic process

After selecting extracts for DA analysis does not simply follow as a next step. "*There is no mechanical procedure for producing findings from an archive of transcript*" (Potter

and Wetherell, 1987 p168). Analysis of this kind is at least partly a craft skill and therefore not easy to turn into a specific recipe. The novice analyst has to learn the skills required to move beyond a 'natural' reading for gist (this is also required when selecting extracts). It takes some time to change this habit. One main difficulty for the discourse reader is in developing an ability to '*render the familiar strange*'. Potter and Wetherell (1987) suggest that as a first step the analyst should approach the data with a set of questions, for example, *"Why am I reading this passage in this way? What features produce this reading?"* (p168). In order to ask these questions the analyst has to be able to examine his or her own ways of sense making. As my previous academic background and professional training has been built around seeking cognitivist explanations, initial attempts to approach the data from a different perspective were difficult. However, this was overcome by reading other DA work, supervision and through lots of practice. I also participated in discourse analysis groups organised by analysts in Scotland. During these meetings members were given the opportunity to bring data along for the group to analyse. This provided me with extra assistance in getting to grips with discourse analytic work in general and with the particular DAM framework chosen for the study. Gradually I developed an ability to set aside the cognitive perspective and I was able to recognise the discursive activities within the interaction. The following set of guidelines was particularly helpful with analyses and the subsequent writing up as it underpins the theoretical approach from discursive psychology.

4.10.1 Analytic guidelines

1. Identify the analytic conclusion to which the observations made in the course of analysis will lead.

2. List the main construction/function points.
3. Order the construction/function points so that they lead logically and persuasively to the conclusion of the analysis.
4. Underline the text that provides the analytic evidence to warrant the making of each construction/function point.
5. Order the analytic evidence so that it leads logically and persuasively to each construction/function point.

This framework (copied from Cowan, 1999) does not intend to make the claim that analyses will follow the order set out above. Often analytic conclusions may be apparent but the construction points may not be obvious immediately. At other times the construction points may be visible but an analytic conclusion may not follow directly. Nonetheless, this framework provided a useful guiding instrument and it offers a relatively systematic approach to the examination of the discursive properties of the text.

4.10.2 Analytic chapters

In the preliminary analysis it was clear that the accomplishment of shared decision-making did not follow any identifiable stages or any particular theoretical framework. Indeed, it was for these reasons that the study was necessary. Furthermore, had it been found that there were indeed identifiable steps to the decision-making process, using these to provide an analytic framework would have been problem for discourse analysis as this would result in setting *a priori* assumptions on the data. Therefore, the following analyses make no *a priori* distinctions between the talk of the doctor and patient and

consider the interaction as a joint product. Both participants are seen as equally concerned in the production of the talk. The next three chapters present three analytic topics that arguably have been identified as representing three key aspects or activities involved in accomplishing decisions in SDM consultations: partnership and patient involvement, requesting behaviours of patients and the subsequent outcomes and, finally, evidence-based practices. At times extracts from the same consultations, at different time points have been used to provide examples of the identified analytic themes. Chapter 5 describes the rhetorical force of first person pronoun use as a form of 'partnership talk' during the discussion of treatment proposals. Chapter 6 describes the construction and action orientation of patients' direct treatment requests. Chapter 7 describes the construction of risk and evidence and the location of agency.

CHAPTER FIVE

Patients, Practitioners, Pronouns and Power

5.1 Introduction

This first analytic chapter involves an examination of how treatments are offered to patients. It is concerned with the discursive activities involved over the discussion of treatments. The main focus of analysis involves an examination of the performative functions of first-person pronoun use when negotiating or accomplishing treatment decisions. The chapter is in two parts. Part one examines three extracts that illuminate the doctor's deployment of personal pronouns and the subsequent actions resulting from pronoun use. Part two examines two extracts and explores the variability of patients' pronoun deployment.

In patient-centred consultations doctors have been found to use 'we' significantly more than patients (Skelton et al, 2002). For example, "We could try this" or "We have a choice of treatment here". Using 'we' in this way can be seen to position the treatment options, as invitations to be considered as opposed to direct instructing or 'doctor's orders' previously considered as paternalistic. Thus, the professionals' use of 'we' could be expected to be more facilitative of a shared approach to healthcare. As part of a larger study exploring the language used in general practice consultations, Skelton and colleagues used a concordancing analysis programme to explore the conventions

surrounding first person pronoun use in general practice consultations. These authors describe the prototypical pattern of interaction in primary care as involving three steps: the patient presents the problem ("*I suffer*"), the doctor provides expertise ("*I think*"), and then the doctor offers a partnership in action ("*we will act*"). This 'process' of interaction may be undermined however, owing to a fundamental ambiguity in the use of 'we'. Skelton *et al* found that when doctors used 'we' it was not clear who the referents of 'we' actually were. They also suggest that when doctors use 'we' they may or may not be aiming to be inclusive and also patients may or may not view the 'we' in partnership terms either. In brief, Skelton *et al* raise concerns relating to pronoun use as facilitative of a power imbalance in favour of the clinician. This chapter explores these issues and examines the performative actions of personal pronoun deployment.

5.2 The action-orientation of doctors' pronoun deployment

Extract one presents part of a discussion between the doctor and the patient over the 'risk factors' involved in having high blood pressure. The doctor informs the patient that the systolic value remains unchanged in spite of the patient receiving treatment that was aimed at reducing it. According to guidelines[12] the patient remains at risk of having a cardiac event if the systolic value remains the same, thus an increase in the medication would be beneficial to the patient.

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[12] The threshold for defining high blood pressure used to be 160mmHg (systolic) and/or 95mmHg (diastolic). However, the suggested threshold has recently been lowered to 140mmHg and/or 90mmHg, which greatly increases the 'pool' of those potentially needing to be treated. *Source* - Annual Report of the Chief Medical Officer 2001

5.3 Extract 1 D5JFM 'Warranting change with trying a wee bit harder'

1. Dr: Right (.) Right (.5) I mean certainly looking at things for the last you
2. know six months or so it's (.) its (.) this systolic value's still been high as the
3. first test and em I think if your other risks are good (.) I mean you don't smoke
4. your cholesterol's good um I just wonder if we should be trying a wee bit
5. harder to lower the first value (.5) You're not getting any si:de e::ffects from
6. the tablets you:'re on
7. Pt: No I would have been telling you right away (unclear words)
8. Dr: That's right cos you had problems with the Amlodipine didn't you but the
9. new (one's:)
10. Pt: (The new one's:)
11. Dr: (agreeing with you.) (.5) what would you thi:nk about us increa:sing the
12. dose a w:ee bit of that and try and get:
13. Pt: Aye (.)Yeah. (.5) I just thought I was doing alright
14. Dr: We:ll you ar::e and you're doing we::ll (.) The thing about it (.5) I could
15. show you some (.5) I've got a computer chart I could show you the difference
16. lowering your blood pressure a wee bit would make if you want to (.5) do you
17. wa:nt to have a look at this
18. Pt: We:ll if you've got the ti:me have you?

After informing the patient that the systolic level is still high the doctor (L1-2) begins the start of an account, formulated to warrant a change in the status quo. The doctor's talk is constructed in such a way to make apparent a process of "thinking", in this case as considering the 'evidence' and relating this to the treatment regime. This reserve or hesitancy adds to the 'thinking it through' approach where the doctor is almost seen to be verbalising some sort of thought process in the patient's presence. This works in such a way so not to appear commanding, for example, the use of 'you *know*' (L1), the

repetition of *'it's'* (L2) and the *'um'* (L4) work to highlight the doctor's attention and consideration. The talk is seen to include rather than exclude the patient from the forthcoming proposition. However, it is also rhetorically persuasive and works to invite consensus.

The explanation that the *"systolic value's still been high as the first test and em I think if your other risks are good I mean you don't smoke your cholesterol's good um ..."* (L2–4) is constructed with a three-part listing device (Jefferson, 1990). The practise of constructing three-part lists has been reported as rhetorically powerful and works to counter potential or real undermining of a speaker's claims. For example it has been identified in political speeches (Atkinson, 1984; Grady and Potter, 1985), courtroom discourse (Drew, 1990); and in everyday talk (Jefferson, 1990). Here, the listing is used to back up the initial claim that the treatment is not working and it provides evidence for the claim. This makes the subsequent suggestion to 'try harder' difficult to challenge and works to make a strong case for what follows *"I just wonder if we should be trying a wee bit harder to lower the first value"* (L4–5).

First the doctor's talk *'I just wonder if ...'* works to make the forthcoming proposition exactly that, a proposition. The doctor is heard to suggest rather than instruct. The second feature relates to *'if we should'*. This has been formulated as a question and again not as a command. The third feature relates to the inference of partnership permeated by *'we'*. Combined, these three activities can be seen to paint a picture of sharing decisions through facilitating patient involvement. However, from a discursive perspective these features can be seen as discursive strategies that build a strong case to invite agreement. All the qualifiers and hesitancy and then the 'we' work to be

rhetorically persuasive. The patient has listened to the verbalisation of a diagnostic process and then right at the end the doctor provides the signal for authority ("we") to act upon it. The 'we' works as a strategy to have the patient corroborate the doctor's claim by placing the patient in the discursive position of either agreeing or the more difficult position of having to 'knock down' all the previous build up.

Up to this point the patient has not yet been seen to actively (verbally) participate. It is fair to expect that the doctor's proposal would seek a response from the patient. However, returning to L5-6 it can be seen that the doctor immediately follows the proposal "*we should perhaps try a little harder to lower the first level*" with a second statement "*You're not getting any side-effects from the tablets you're on*". There are three further points to note here. First, the patient has not been given much time or space to respond to the doctor's initial question. Second, the doctor's follow on statement works to effect a change in agenda with a topic shift. By holding the conversational space and its trajectory in terms of the way the topic is constructed, the doctor can be seen to be in charge of the agenda. Third, when the patient does respond it is clear that the response is not directed to the invitation to consider the implied medication change (L7). This response ends with some unclear speech. There were no problems with the quality of the audio recording so it would appear that the patient is in fact muttering. It would also seem appropriate to suggest that when people mutter there is some interactional business going on. That is, here the muttering appears to serve some particular discursive purpose and it may indicate some disagreement or reluctance with what has just been said.

Prior to line 11 the doctor had not made explicit what exactly was meant by working a bit harder to lower systolic pressure. It should be noted that the patient would not know for certain what exactly the doctor was suggesting until then. It becomes apparent that the patient's muttering is heard as a challenge to the initial proposal when the doctor's next utterance is examined. The words *"That's right"* should have been enough to acknowledge the patient's comment (L7). However, the utterance is expanded. The doctor provides extra information by doing some remembering "*That's right cos you had problems with the Amlodipine didn't you and your new one's ... (L8)*". There are two particular features at work within this statement and both do subtle defensive and offensive rhetorical business. The first relates to the business of 'doing remembering' (Edwards and Potter, 1992) and the second relates to the issue of agency although they can be difficult to disentangle. It has been shown that when people recount events from the past they are not simply telling a story as if automatically downloading from a memory store due to some trigger. The account or description will be constructed in such a way as to perform particular actions or in Potters words, *"the past is reconstructed according to the functional concerns of the present"* (p24). Facts are 'remembered' and constructed in such a way as to prevent undermining. So, in order for a claim to achieve success agreement needs to be reached about what the case *was* and what its relevance *is* in the here and now. In this extract the utterance in Line 8 and 9 has been formulated to bring about some 'joint remembering' and is set up to request agreement from the patient. This joint remembering makes it difficult to challenge the doctor's claim. Note the phrase "*cos you had problems with the Amlodipine didn't you*" (L8). Here the locus of the problem is positioned with the patient. This is a subtle but powerful rhetorical construction that works to remove attribution away from the drug or its side-effects. The '*didn't you*' is a follow-up question that invites agreement. In

addition, the patient is unlikely to be in a position to disagree owing to a lack of 'medical expertise'. Therefore, the patient is put in the discursive position of having to accept the doctor's attributions as a matter of fact or, in effect having to challenge this 'expertise'. Consequentially, the patient is not given a choice.

Issues of agency are intertwined with the business of 'doing remembering'. Although the patient is seen to agree with the doctor's statements this agreement is not without comment. The doctor is informed that the patient would do what would be expected in those circumstances, i.e. report any concerns to the doctor (L7). The form and content of this utterance suggests that the patient is attending to an issue of personal stake and interest. In other words, the patient is making relevant the issue of personal responsibility, as related to the interactional identity category 'patient', to keep the doctor informed of such things.

Next, the doctor is seen to ask an open question *"what would you think about us increasing the dose a wee bit of that and try and get"* (L11-12). The referent of 'us' is ambiguous here. It is not clear if the doctor means 'you and I' or if 'us' refers to the doctor 'et al'. Whilst this open-ended question appears to provide the patient with an opportunity to provide an opinion (and thus, be involved in the decision making) the minimisation of the proposed change with the words *'a wee bit'* may work to persuade the patient to align and agree with the doctor's suggestion. Although the doctor's utterance appears as an invitation it is constructed to be rhetorically persuasive.

The patient's response to the proposed medication change *"Aye, yeah, I just thought I was doing alright"* (L13) does not bring outright agreement however, rather, it implies

some reluctance. This comment places the doctor in a delicate situation. To give unreserved agreement to the patient's comment would undermine the reasons given earlier for the proposed increase. After telling the patient that he/she is doing fine and in order not to contradict the reasons given for the proposed change, the doctor introduces an external agent into the discussion, a cardiovascular risk prediction tool (CRPT)[13]. By inviting the patient to use the decision tool the doctor is provided with an 'external' arbitrator that is used to resolve any potential or real discrepancy. By introducing the patient to the decision tool the doctor's earlier warranting can be corroborated and strengthened with the help of this external agent. Additionally, this external agent (the decision tool) also provides an 'impartial' factual agent that adds further warranting to the doctor's claim that a medication change is required.

In sum, extract 1 has illuminated how the doctor's talk is constructed to provide a justificatory account warranting the proposal to increase the dose of medication. The account is seen to deploy a number of discursive strategies and resources to attend to this warranting and also issues of personal stake and interest for the doctor. Some of the strategies drawn on include the deployment of rhetorically ambiguous 'partnership' pronouns, three-part listing and using external agents i.e. a risk tool to invite consensus and patient corroboration.

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[13] CRPTs are relatively new instruments that are used to aid clinical decision-making for patients at risk of cardiovascular disease. These tools are used to formally identify high-risk patients and the likelihood of having a cardiac event over the next 5 -10 years. The format of these tools can be e.g. paper-based tables or computer software packages. Patient information is entered that generates a prediction for future events and specific recommendations for the patient. The overall role of the tool is to standardise and improve accuracy of the clinician's decision but also provide information to the patient that may or may not facilitate involvement in the treatment decision-making.

The next extract presents a further example where 'partnership' talk is found to be ambiguous. In terms of SDM competences[14] the talk can be seen to help negotiate treatment options and attend to the business of checking out the patient's ideas, fears and concerns relating to his/her condition and its treatment. The patient is attending the doctor for a review of the medication regime for Temporal Arteritis[15], prescribed by the specialist. Both the patient and the doctor had earlier expressed concerns over the dosage of the proposed steroid treatment.

5.4 Extract 2 D2CCF 'The business of sharing responsibility'

1. Dr: I (.) I would (.) let's cut (.) let's let's sort of go middle
2. ground say a month and then we can start reducing it (.5) I
3. think okay (.5) Right that's fine.(3 second pause while reading letter)
4. Yeah that's just breathing tests (.) Yeah (.) because you started the
5. Methotrexate but it doesn't matter that you have a:ctually
6. started it they just want to get a base line near the beginning
7. Pt:(Right)
8. Dr: (so, em) that's today
9. Pt: Yep
10. Dr: Yes (looking at letter)Fine (.5) just a breathing test (.5)
11. just as a base line
12. Pt: With time for a (.) a bite of lunch in between (laughing)
13. Dr: Yes (laughing) I know (.5) Okay (.) Can we check your blood
14. pressure today and j:ust s:ee what it's do:ing (.) other than that
15. we were just seeing how y:ou were doing really (.) wasn't it and
16. just making sure that things were working out okay with you.
17. Pt: I don't feel any dramatic difference I thought I would (have:)

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[14] See table of competences p37

[15] Temporal Arteritis is a condition that originates from a generalized vasculopathy affecting medium and large arteries. Early recognition and treatment remain critical to prevent monocular or binocular blindness. Visual impairment results from inflammation of branches of the ophthalmic artery, particularly the posterior ciliary artery, leading to *ischemic optic neuritis*. Additionally, the central retinal artery is affected, and almost one half of cases involve loss of eyesight. Oral steroids are reported to be effective in treating this condition. Source: www.emedicine.com

18. Dr: (Mhmm)
19. Pt: felt something happening (Laughter)
20. Dr: And we'll need to check (.5) I will need to make sure they
21. write down that we need to check your ESR again sometime
22. that hasn't been done the last couple of times (.) I will maybe
23. put that in just to (.) that's grand (.) Okay (.) So you won't (.) You
24. won't have been on (.)You have been two weeks (.) a week on
25. the h:igher dose of steroids n:ow
26. Pt: 2 weeks
27. Dr: 2 weeks yeah so I'd give it another 2 weeks and then
28. we will start the reduction that we talked about (.5) Do you
29. re:member what we s:aid
30. Pt: d:own to nineteen is i:t (.) I don't think we went as far as fifteen eh no
31. Dr: Well they are down at two point five milligrams mgs (.) I will need to
32. give you some two point five milligrams mgs
33. Pt: oh yeah
34. Dr: so you will be seventeen point five em
35. Pt: Mhm hmm (.5) in another two weeks
36. Dr: For a (.) they said two months so I think we should do it monthly though
37. Pt: Right.
38. Dr: Yeah it just seems an awfully long time to reduce it em so
39. I think month
40. Pt: So two weeks today I'll reduce it to seventeen point five
41. Dr: to seventeen point five for a month
42. Pt: Okay Dokey

At the beginning of the extract the doctor makes a suggestion as to how the treatment plan could proceed. Lines 1–3 shows the doctor displaying some hesitancy formulating and reformulating the forthcoming 'option' to make changes to the medication regime. The hesitancy and repair seen in the first line highlights the ways the doctor constructs attention to opposing or alternative positions. Again this works to verbalise the 'thought process' in the presence of the patient. Here the doctor is seen to break off from telling the patient what he/she would do. This works to emphasise the 'we' and therefore,

inclusiveness and immediately shows that the original 'I would' is unsatisfactory for the doctor. In these circumstances it could be reasonable to expect the doctor to make the decision to act against specialist advice. This would be an occasion where general practice expertise might take precedence over specialist advice. It is GPs who are responsible for the management of everyday decision-making when a patient is under specialist care. However, the reformulation and repairing is more indicative of a delicate situation. Earlier in this consultation (before the extract presented) it was made apparent that the doctor and the patient had particular concerns with the dose and the duration of steroids prescribed by the specialist. Thus, any change to the advice proposed by the specialist will require some diplomacy because there is a potential dilemma for the doctor in this situation. To alter the specialist's treatment plan the doctor is questioning the expertise of the specialist. Therefore, the doctor will be responsible and accountable for the decision and not reformulating the 'I would' to 'let's cut' would have placed the doctor in the position of sole agent for the decision to change the medication. The doctor's repair works to 'share' the decision and in effect agency and responsibility is shared with the patient.

In addition, the words 'let's cut, let's, let's sort of go middle ground say a month and then we can start reducing it' (L1-2) constructs an invitation and an inference that the proposed change is not too severe, i.e. the 'middle ground option' is offered as something of a positive compromise. The words 'say a month' further invoke a picture of inviting negotiation and patient participation. But again it could be that this sort of indirect and hesitant doctor talk is difficult to undermine if it is heard as a kind of verbalised medical 'thought process' which is uttered to the patient as a sort of commentary on what is leading to the proposed course of action. This formulation

makes the proposal difficult to challenge or reject. However, the patient is given little time to respond to the invitation. The doctor continues by changing the topic. The talk in lines 3-7 is a summary that works to bring an end to the negotiating phase as if the agreement has already been reached. When the patient is given room to comment the response is ambiguous however. It is not possible to determine which part of the doctor's talk it is that is being responded to when the patient says 'Right' (L7) and 'Yep' (L9). It might be claimed that as the patient had expressed concern with the steroid treatment earlier in the consultation then it is reasonable to expect that the doctor's proposal may be just what the patient wanted and the response here indicates agreement. However, it is more likely that the 'Yep' and 'Right' are just continuation markers. The patient's next response indicates some unease with what the doctor had just said, "With time for a a bite of lunch in between (laughing)" (L12). Although this comment may appear as a simple attempt at humour this remark is performing delicate work. The presence of laughter has been described as a discursive strategy that works as either a remedying or legitimising feature (Hakaana, 2001). It has also been claimed that patients' laughter tends to be unreciprocated by the doctor. One reason offered to account for this is not returning laughter may work as a means of acknowledging that the speaker is dealing with a delicate issue and reciprocated laughter may be heard as insensitive. On this occasion the laughter was briefly reciprocated before the doctor returned to 'business as usual'. This is likely to indicate that the doctor had either not identified anything untoward in the patient's utterance or that the doctor has opted to avoid picking up on the comment made by the patient.

The use of 'we' in the topic shift (L13-15) is not seen to accomplish 'partnership' or patient involvement. The 'we' use in "Can we check your blood pressure today" and

"we were just seeing how you were doing really" is ambiguous and impersonal and it does not intimate the referent of 'we'. Thus, whilst it implies inclusiveness, e.g. 'you and I' it does not accomplish any 'partnership' between the doctor and patient. Nevertheless, the 'we' deployment helps to turn the request into an invitation rather than a command and therefore, merits a response. Again, the patient is given little space to respond to the doctor's comments because after asking to check the blood pressure (L13) the doctor continued speaking and retained hold over the conversation and the agenda setting with "Other than that we were just seeing how you were doing really wasn't it and just making sure that things were working out okay with you" (L14-16). The instances of 'just' in this utterance can be seen to have a 'restrictive meaning' in the sense of 'only' (Lee, 1987). The orientation of 'just' marks out the boundaries of what can, or cannot, be discussed in this particular consultation. This limit setting makes it difficult for the patient to make the implicit concern in L12 plain and direct. The construction of the doctor's talk did not provide an opening for the patient. The patient's next response is also constructed to orient to a sensitive concern "I don't feel any dramatic difference, I thought I would have felt something happening (laughter)" (L17and 19). Here, the laughter helps to make an implicit request for further explanation or acknowledgment of the expressed concerns. The fact that the patient did not make a direct request may be the result of the previous talk marking out the remit for the rest of the consultation. Further, this response had introduced a 'newsworthy' comment (Jones, 2001). The patient attempted to inform the doctor of existing concerns about a lack of progress. When patients provide newsworthy comments or responses it has been reported that patients expect some form of assessment from the doctor e.g. further questions that would enable discussion or exploration of the patient's concern (Jones, 2001). On this occasion the doctor's response is 'Mhmm' (Line 18) followed by

a topic shift. Continuers such as 'Mhmm' may on some occasions work to encourage patients to expand on their last comment. Jones has reported however that 'acknowledgement tokens' such as 'okay', 'umhm' etc. are seen to display doctors' inattentiveness. In addition, Jones claims they are viewed as troublesome by patients and treated with silence. In this extract, because of the doctor's subsequent topic shift it can be seen that the 'Mhmm' was essentially perfunctory. The doctor's response did not acknowledge the comment was a direct expression of concern. Thus, the doctor missed an opportunity to explore any potential 'worry talk' as a feature of the interaction at that point and the consultation in general.

Subsequent reference to the medication change implies that it has already been agreed upon and the doctor is seen to move on to checking out the patient's understanding of the dose rather than ascertaining that the change is acceptable "Do you remember what we said" (L28-29). Bearing in mind that the patient's attempts to discuss any concerns were not pursued there is no further attempt to reintroduce them, but instead concession and alignment with the doctor's suggestions.

Extract 2 has revealed that, in spite of the repair to make the medication change a negotiated event, it did not quite accomplish this. Instead, the repairing by the doctor was seen to attend to personal accountability issues and through the business of sharing the doctor's responsibility for changes in the steroid dosage was minimised. Changes in topics at crucial moments limited the patient from becoming fully involved in the decision. In addition, the doctor did not 'hear' the patient's implicit concerns and instead carried on with the consultation as if the patient had given unreserved

agreement. Pronoun deployment was seen to help avoid the imputation of coercion and worked to persuade the patient to align with the medical agenda.

The next extract is taken from a consultation where the patient has reported experiencing unwanted side-effects from the current anti-hypertensive medication. It too illustrates the ambiguity of 'we' use. The extract begins after the doctor has reviewed the history of the patient's anti-hypertensive medications and is about to propose a change. On one level it would appear as straightforward information sharing. However, as already reported, the business of 'doing remembering' performs other functions besides sharing information. Here, the remembering can be seen to prepare the ground for forthcoming changes.

5.5 Extract 3 D2MSF 'The three reasons to stop it puzzle'

1. Dr: So then we changed to this Lisinopril (.) I think that we should change
2. tack completely (.5) I think that we should:
3. Pt: Take me (off:)
4. Dr: (Stop) it (.5) I think for (.) we::ll (.) we've got three reasons to stop
5. it really h:aven't we
6. Pt: Mhmm
7. Dr: One it's not working (.) two it may well be making you feel a sort of
8. feeling in your (.) feeling in your nose and throat
9. Pt: Yeah
10. Dr: and we'll find out by stopping it cos that will be better
11. Pt: Aha (.) Yes
12. Dr: And the third thing is with your potassium being up a wee bit then
13. it's (.) you know a:h (.) it just doesn't all fit together
14. Pt: Mhmm
15. Dr: So I would be happy if you just stop it and what we'll do is we'll
16. choose something completely different (.) that.(.) that's (hhh) there's not

17. one tablet better than another but there's a certain pattern that it's worth
18. going through
19. PT: Aha
20. Dr: because tablets have other effects that are good for you as well
21. Pt: yes
22. Dr: That was the reason for choosing the Lisinopril.
23. Pt: Aha
24. Dr: But if it can't be used it can't be used
25. Pt: Mhmm
26. Dr: What I would suggest instead is one that's completely different
27. It's called Doxasin (.) doesn't really matter what it's called (.) b:ut:
28. Pt: Mhmm
29. Dr: Em (.) and again we would start off with the tiniest dose (.5) the good
30. thing about it is it doesn't involve any blood tests (.5) em no blood test
31. needed although I would like you to have another blood test to check
32. up this potassium:
33. Pt: Yes
34. Dr: has settled itself (.5) but from the point of view of the blood pressure
35. tablet no blood test needed
36. Pt: Mhmm
37. Dr: It would just be a case of keeping an eye on your blood pressure:
38. Pt: Yes (.) will I have a test tomorrow or will I wait a (.) next
39. week's Christmas so:
40. Dr: Yeah

After the review concludes with a suggested change (L1-2) the doctor constructs a justificatory account. Warranty for the proposed change is provided with "well we've got three reasons to stop it really haven't we" (L4-5). The first point to note is that the doctor's use of 'we' may have been deployed to include the patient in the proposal to change treatments. Here the 'we' and 'haven't we' is seen to help to invite agreement alongside the 'haven't we' and the minimal response 'Mhmm' is not taken up as an

agreement but as a request for further information. This is provided with the further elaboration that there are three reasons to stop it.

Again, the three-part-listing provides an effective resource that can be used to do a number of things. For example, work to prevent the speaker from being interrupted and summarise some general class of things (Potter, 1996 p196). Both of these activities can be seen in the following accounting.

The first reason offered to warrant the change is that "the treatment isn't working" (L7). The second reason is "it may well be making you feel a sort of feeling in your ... feeling in your nose and throat" (L7-8). This statement is noteworthy in the sense that causal attribution is not positioned with the patient but instead it is placed with the medication. In other words, accountability for the problems with the current medication is attributed to unwanted side-effects. The third reason is "*And the third thing is with your potassium being up a wee bit then it's you know ah it just doesn't all fit together*" (L12-14). With the third reason the doctor can be seen to present something of a puzzle to the patient. The inference here is that the increased potassium level cannot be explained, 'it doesn't all fit together'. The following sequence of talk was taken from earlier on in this consultation and is presented to provide a context for the present discussion.

Dr: Oh hmm it' still up a bit
PT: Wh:at was it (.) the potassium like 'J' (partner's initial)
Dr: Mhmm. (.)It's a bit of a puzzle
Pt: Well I haven't had any bananas
Dr: No No (.) since his has been up (.5) that's strange that the two of you have had the same thing (.5) but certainly it's up
PT: Gosh

Dr: A:h (.) what a:re we going to do with y:ou (.) we:ll let's **check** your blood pressure

At the beginning of the consultation the patient had reported a sore throat/tickly cough. When the doctor first reported that the patient's potassium levels were up and that this was a puzzle the patient had replied by saying he/she had not had any bananas. This response indicated that the patient knew bananas contained potassium and in addition the doctor's talk was heard as locating the 'problem' at the level of the agency of the patient. Thus, the patient's response aimed to counter potential blame that the increased potassium level had arisen from eating bananas or something that he/she had done. What is rather unexpected here is that there should be no mystery about the potassium level as far as the doctor is concerned. The anti-hypertensive drug is known to increase potassium levels. The patient is not directly informed of this. One question to ask here is why did the doctor not say this clearly? On two occasions the doctor has been seen to view the potassium increase as something strange. The doctor leaves the patient to deal with this 'puzzle' by not providing information that could put the patient at ease. It appears that the puzzle construction adds weight to the warranting of the proposed change.

The three-part listing used here is difficult to challenge and so it helps to construct a strong warrant to stop the treatment. However, the way this is formulated may aim to present a picture of inclusiveness and sharing between the doctor and the patient. This is seen on the eight occasions that 'we' was utilised by the doctor between lines 1-12. However, the 'partnership talk' is rhetorically constructed to prevent any suggestion of persuasion or pressure. A further feature noted in the doctor's talk is the use of the personal "*so I would be happy if you just stop it*", (L15). This instruction is not

constructed using professional expertise or the voice of medicine. The use of 'I' and the affective and emotive use of 'happy' places the onus to 'please' with the patient and works to show who has authority in the consultation in terms of an invitation to align with the interactional identity of the doctor in terms of medical expertise.

Overall, analysis of this extract describes how pronoun deployment, joint remembering and three-part listing provides the doctor with persuasive rhetorical devices that work to warrant the decision whilst masking imputation of coercion.

5.6 Summary of part 1

In part one, analysis has so far revealed variation between the construction and action orientation of the deployment of first-person pronouns. For example, where 'we' helps to 'invite' rather than instruct or order, where 'I' was changed to 'we' to help share responsibility for the decision and where essentially very little sharing was actually accomplished.

The first three extracts illuminated and revealed the complexities involved in what may have appeared initially as straightforward examples of negotiation and sharing of treatment decisions. What has been observed is that doctors' use of 'we' does not always contribute towards accomplishing a partnership in treatment decision-making as perhaps was first indicated. It appears that the use of "we" by doctors acts to take hold of the decision-making agenda by adopting a collective voice. This in essence has been shown to add weight to the authority of the decision whilst masking the "I", the doctor's agency, in uttering it. The next section provides examples of variation in the action-

orientation of pronoun use. Here, 'we' and 'I' use is seen to aid patients' involvement in decision-making.

5.7 The action-orientation of patients' pronoun deployment

While the previous extracts explored the doctors' deployment of 'we' and other 'partnership' talk, the next set of extracts provides examples of first-person pronoun use that reflect more active participation from patients. The first of these presents a sequence of talk, taken from a consultation where the patient can be seen to direct the flow of the conversation, using similar discursive resources and strategies that were used by doctors in part 1.

When examining the performative actions of 'we' deployment in the next set of extracts it is possible to identify subtle differences in what 'we' can be seen to do during option negotiation. In Extract 4 the patient presents the doctor with three concerns and here the analysis shows that treatment negotiation is more conducive to partnership with the patient.

5.8 Extract 4 D5CBF 'Providing the patient with space to choose'

1. Pt: So originally when I made the appointment it was
2. only to see you about my HRT
3. Dr: Mhmm
4. Pt: And to ask you a question about my eye but I've
5. taken his flu thing and I feel absolutely gubbed with it
6. Dr: Okay (.) Wh:at do y:ou want to deal with first (1.)
7. Pt: Right (.) the HRT (.) it's due in about (.) I think

8. it's a week or a few days or whatever
9. Dr: You're on Premanin a:ny problems with it
10. Pt: No problems apart from the weight thing which (.)
11. God I tried that (.) is it fat bustin' s:oup (.) It's okay (.)
12. I lost about five pounds
13. Dr: It is difficult (.) people (.) people
14. Pt: (Oh it drives me bonkers)
15. Dr: (put on weight with the menopause) anyway and it's
16. really hard to control
17. Pt: It gets me down a bit (.5) my mum says "well what
18. happened to my slim little girl (.) Mum I'm not a little
19. girl and I'll never be slim" (.) You know (.) anyway that
20. doesn't matter. (.5) That's the least of my worries (.5)
21. and another thing I came to ask you (.) this mark on my eye (.)
22. I just want your opinion about it (.) It started off a long
23. time ago (.) It was a little pluke and it just seems to have grown.
24. Dr: Mhmm (1.0) it is (.) it's a little c:yst is:n't it (.5) It is a little cyst
25. Pt: Mhmm (.) I'm quite happy to leave well alone but
26. I thought I'm going to ask
27. Dr: I'm just wondering if we could maybe just put
28. something in it and take it out (.5) whether it would work
29. (.5) I probably would be able to do that actually now (.) Do
30. you want to um get it done (.) I mean all I would do is
31. just open that up and let (.) I mean it's a very superficial
32. cystic thing.
33. Pt: Right
34. Dr: If it comes back then obviously if you wanted it
35. we could:
36. Pt: Well c:an I a:sk you a few things while you're d:oing it
37. Dr: Okay (.) No problem
38. Pt: Okay (.5) Can I take my coat off because I'm b:oiled
39. Dr: Please do and leap up (.5) I always like people lying
40. down when I'm doing things to them
41. Pt: I know this cold thing will need to just run it's
42. course but I am meant to be working tonight and I don't
43. really know whether to head in or not

At the beginning of this consultation the patient identifies three items to be addressed and the doctor extends an invitation for the patient to choose which item to discuss first (L6). The first point to note is that the doctor does not decide alone. Second, the formulation of the invitation does indeed provide an invitation. This contrasts with what was found in earlier, i.e. invitations do not always work to invite. As is indicated by the transcription notation, the doctor can be seen to give the patient time to respond. This appears as a notable event. The patient is seen to take up the invitation and makes the decision to attend to HRT first (L7 –8). Whilst this may simply suggest that the patient wants to attend to the most important concern the point made is that the doctor invited the patient to make a choice.

In line 9 the doctor says "any problems with it". Note the absence of subjectivity here. The agency factor relating to causal attribution for potential problems of HRT has been depersonalised. The doctor did not ask, 'are you having any problems?' Thus, implications of blame and responsibility (for potential problems) have already been relocated away from the patient.

The patient responds by reporting 'the weight thing' (L10-12) and provides the doctor with an expanded answer. This response can be seen to perform a number of actions. First, information asked for has been provided. Second, the expansion raises the issue of weight as a matter of concern. Third, the expanded detail helps to construct the patient in a positive light. The patient is informing the doctor that she has taken some responsibility and (successful) corrective action by attending to the weight gain herself. This talk paints a picture of a 'good patient' and follows the ideology where individual responsibility for health is positively constructed. The doctor's next utterance indicates

that the patient's concerns have been 'heard' with the acknowledgement "*It is difficult*" (L13). It becomes apparent that the doctor takes up this comment as a potential criticism of the treatment. The utterance "*It is difficult (.) people (.) people (put on weight with the menopause) anyway and it's really hard to control*" (L13 and 15) attributes the 'weight thing' to the menopause rather than the treatment This talk is seen to provide much more than a straightforward reporting, it attends to issues of attribution. The concern over weight has been addressed by the implication that if the medication is not responsible for putting on weight, the menopause would be. This construction works to imply that the reasons for weight gain may be outwith the patient's control. In addition this acknowledges the implicit concerns the patient is describing without undermining either of the participants' concerns. The doctor's talk has also constructed matters in such a way as to open a space in the consultation for the patient's agenda to be hinted at and then it is left open for the patient to choose to take up or not.

Next the patient is seen to validate her claim that she has put on weight with the help of 'active voicing' "well what happened to my slim little girl? Mum I'm not a little girl and I'll never be slim" (L17 –19). The use of this kind of active quoting has been shown to be a powerful strategy for preventing a claim being undermined on the grounds of ambiguity or scepticism. This device helps emphasise the authority of others' beliefs and also works to strengthen claims. By emphasising the primacy of others' beliefs 'as if' the use of others' words or voices works to provide a stronger claim for truth. According to Potter (1996) the deployment of active voicing "*can provide (like ventriloquists' dummies) life, opinion and personality of their own*" and can work to provide consensus and corroboration of the claims being made. Here, this adds credibility to the patient's claims by providing external corroboration. In this segment of

talk the patient's mother has been introduced into the picture. This allows inferences to be made relating to the 'unique' position that being a mother one would know whether or not one's daughter had gained weight, thus adding to the rhetorical force of the patient's claim. The use of this discursive device has been described as being at the basis to lay reasoning when providing consensus and corroboration and can show how consensus and corroboration is not simply a thing that's done whilst constructing objectivity and facts, but that it is managed and worked up as a result of the construction of claims (Potter, 1996). It appears that the active voicing has been successful for the patient as she concludes with the words "anyway that doesn't matter. That's the least of my worries" (L 19 -20). The subsequent topic shift can be regarded as patient 'initiative-taking'. This is noteworthy in the sense that, in this dataset, it is usually the doctor who initiates topic shifts, and this example indicates that it is not always one-way from doctor to patient.

So far, analysis of this extract has provided an example of how participants' talk can be formulated to help participation and involvement in decision-making. Here the patient was given space to take up the invitation and thus, to take the initiative. The next sequence of talk (from the same consultation) shows how the doctor's use of 'I' appears to help with the negotiation of the treatment procedure the doctor has just suggested. This talk continues to construct collaboration and partnership. After the doctor explains that the patient has a cyst on her eyelid (L24) the patient is given the opportunity to have it removed. This offer of instant treatment is constructed as an option for the patient. The words ' I'm just wondering if we could maybe just put something in it and take it out' implies that the doctor has not yet decided for sure and invites a response from the patient. The doctor has not 'told' the patient what will be done e.g. 'I will

remove this cyst now. In fact, the doctor explicitly asks the patient directly 'Do you want to um get it done? (L30) and seeks clear agreement. In lines 30-31 there is no ambiguity with the doctor's use of 'I' so this makes the doctor's talk suggestion more personal. It could be argued here that the patient is not given an opportunity to respond immediately to this question because the doctor continued speaking. If this was the case then the doctor's talk could be regarded as coercive. However, when the doctor has finished describing the procedure the patient is given room to comment. It appears that the construction of topic shifts is crucial. On this occasion the doctor's expansion did not result in a topic shift, nor did it restrain the patient from speaking. Instead it was seen to provide the patient with further information on which to base the decision. This is another feature that can be regarded as being co-operative and conducive to sharing decisions. The doctor's expanded talk between lines 28-33 had made available both a choice and enough information for the patient on which to base the decision. The patient's subsequent response indicates that there was some consideration before agreement was reached. It has not been accepted unconditionally or as a matter of routine. The response to the option is formulated as a compromise, it is conditional "Well can I ask you a few things while you're doing it?" (L37). For the patient this utterance seems to operate as a means of retaining some active involvement in the decision-making process. The doctor agrees to the request and the patient is seen to ask the doctor about the 'few things'. Again, this is something of an unusual event. In the dataset it tends to be doctors who ask further questions when carrying out procedures. The doctor's response makes available the space for the patient to ask further questions and, thus continues to facilitate patient participation and a shared decision.

In summary, analysis of Extract 4 has identified some common discursive devices and strategies at play in this consultation, e.g. the deployment of three-part lists, consensus

and corroboration and active voicing. The performative aspects of these are seen to contrast with those seen in the first part of the chapter. On this occasion, the deployment of these devices helped construct an account of the menopause, medication and patient issues as objective and neutral. In addition, the patient was given the opportunity to participate in decision-making and did exercise agency in this respect. The doctor's use of 'I' was seen to aid the negotiation business and facilitate patient involvement in the sharing of a treatment decision because there was no ambiguity apparent in its use.

The next extract has been selected as it presents a slightly different picture of the performative action of 'we' pronoun use, that impacts on the nature of the decision-making business. It has been claimed that patients do not use 'we' in the context of meaning 'you and I doctor' (Skelton *et al*, 2002). Here, it can be seen that the patient's use of 'we' helps the patient take control of the conversational flow and trajectory of the consultation.

As was the case for all the recorded consultations the doctor would check with the patient before commencing that the patient still consented to having the consultation recorded. Here the patient's response is different than most other patients. Where they tended to make only minimal consenting remarks, this patient had more to say.

5.9 Extract 5 D2LMF 'Reversing roles and taking charge'

1. Dr: Hello
2. Pt: Ha:llo
3. Dr: How are you today (.) are you a:greeable to our little study:
4. Pt: Yeah (.) they can listen to what I have to say I suppose (..5) what

5. we have to say (.) Its no going to be anything too thingmy I don't th:ink
6. Dr: too confrontational
7. Pt: I don't think so
8. Dr: Apologies for starting a bit late to begin with
9. Pt: Ha Ha Ha (.) thank you for that (more laughter)
10. Dr: So what's new
11. Pt: We:ll (.5) wh:at are we going to do (.5) discuss my fo:ot or the blood
12. pressure first
13. Dr: Em (.5) Will:
14. Pt: Or will we have another appointment for one or the other (.5) No
15. Dr: No we'll need to discuss your blood pressure
16. Pt: Right
17. Dr: and just at the end last time we were suggesting you increase your
18. Oxytbutin:
19. Pt: That's right.
20. Dr: intake to help the urinary frequency (unclear few words)
21. Pt: well I've just come off it altogether
22. Dr: H:ave y::ou
23. Pt: (hhh) because it just wasn't hel:ping in my opinion (.) It made me have
24. to strain to pass urine when I had to go and I'd rather just carry on at
25. the moment (.5) Right (.5) okay so now we are discussing the (1.)
26. Dr: blood pressure
27. Pt: Blood pressure aye (.5) do you w:ant to take it

As has been found to be a common feature in the dataset, the doctor is seen to ask two consecutive questions (L3). It is the second question that is answered when the patient consents to the recording of the consultation (L4-5). The patient's response is reformulated by replacing 'I' to include the doctor "what we have to say". This reformulation orients to an awareness of the patient's own position with that of the doctor's and works to construct an 'us' on this occasion. On this occasion the 'reality' of 'sharing decisions' has essentially been constructed as a given by both participants with the doctor's reference to 'our little study' at the beginning of the extract. In

addition the use of "little" downplays the study's importance in the consultation as a medical event or even the study in general.

The referent of 'thingmy' in the patient's comment "its not going to anything too thingmy I don't think" (L4) creates an apparent ambiguity. The doctor is left to decide what was meant by 'thingmy' and attempts to clarify this by suggesting a substitute. What is interesting is the choice of replacement and the patient's subsequent response to it i.e. 'confrontational'. The "I don't think so" reply by the patient (L8) suggests the doctor's response was not an unexpected one (as 'confrontational' potentially could have been rejected had the patient viewed this as erroneous).

The doctor returns to the consulting business by asking, "*so what's new*" (L10). An expected response to this would be for the patient to state the reasons for the visit. What is rather unusual here is that the patient turns the doctor's question around and asks "*We:ll (.5) wh:at are we going to do (.5) discuss my fo:ot or the blood pressure first*" (L11-12). From a conversation analytic perspective the doctor's 'opener' or 'first concern elicitor' here is unusual (Button and Casey, 1984). Gafaranga and Britten (2003) have reported that this type of elicitor deviates from the normative framework, where it is expected that doctors will open with 'How are you' or 'What can I do for you' and therefore, will need to be repaired by one of the participants. Gafaranga and Britten reported that unless it is repaired then deviations such as these can result in a misalignment between participants and can have negative consequences for concordance and 'mutuality'. From this perspective then it could be seen that the form and content of the opener here has presented a request for information in an unconventional way and has resulted in an interactional problem for the participants. As

the extract shows, this consultation could be described as a follow-up one rather than for something new (i.e. part of the reason for the visit was to find out the results from a specialist). This opener suggests that the doctor did not know why the patient was there. From the discourse analytic perspective the patient's utterance can be seen to be working to exercise agency.

It has been noted in this dataset that on most occasions when patients have more than one item or concern to be attended to there appear to be two ways of orienting to this. Either the doctor constructs an invitation for the patient to choose or the doctor makes the decision alone. On this occasion however, the patient is the one who extends this 'invitation' to the doctor. The patient has asked more than one question before waiting for a response and, similar to previous examples, the 'question receiver' (this time the doctor) is not given space or time to respond in full. The patient is seen to block the doctor's attempt at a response by interrupting (L13) and suggests another option. This positions the patient as the one setting the agenda and holding control of the consultation. Lines 16-21 show that the doctor orients to this with the response "*we'll need to discuss your blood pressure*" and "*and just at the end last time we were suggesting you increase your Oxybutynin*". The point of interest here is the doctor does not address the 'foot' issue and instead introduced a hitherto unspecified (by the patient) medical concern relating to urinary frequency. By omitting or changing the second item on the patient's list, the doctor's talk is an attempt to take back control by returning the conversation around to include his/her agenda.

After the patient informs the doctor with "well I've just come off it altogether" (L22) the doctor's emphasised response "*have you*" not only indicates a question but works to

question the patient's authority in taking the action to stop the medication. This becomes clear as the patient orients to the question by supplementing his/her response with a 'medical' justification as opposed to a number of potential 'non-medical' alternatives *"because it just wasn't hel:ping in my opinion (.) it made me have to strain to pass urine when I had to go"* (L23-24). By being explicit it becomes difficult for the doctor to undermine the reason offered for stopping the medication. It might also be argued that the patient's use of medical language makes it more difficult for the doctor to challenge the patient. In addition, the patient does not leave much space for the doctor to comment further "and I'd rather just carry on at the moment. Right, okay so now we are discussing the (blood pressure) do you want to take it" (L24-27). This formulation of the patient's account appears to be successful. The doctor does not return to the issue, and the patient can be seen to retrieve control and bring the discussion to an end by returning to the earlier agenda.

In this extract the analysis has identified that it is not always the doctor who is in control of the agenda. The patient was seen to continue taking an active role in the treatment decision-making. Control and power was passed back and forward through the deployment of a number of discursive strategies. Throughout it was evident that this patient had used 'we' unambiguously on a number of occasions as a referent for the doctor and him/herself. It is clear that this worked to be rhetorically forceful and the patient's use of 'partnership' talk has enabled him/her to take or negotiate a high degree of control in the interaction.

This ability or 'presence' for patients to take the initiative (and thus, control) is not the norm in the dataset however. It does appear as something quite exceptional. This extract has identified and described how the performative activities of talk can be seen

to pass power and control back and forth. It therefore offers more of an indication of how a shared decision can be accomplished.

5.10 Discussion

In everyday conversation it is routine to provide an explanation when what you are about to say runs the risk of being disputed or undermined by the listener (e.g. Potter, 1996). Speakers will utilise a variety of discursive strategies to counter this potential problem. Pronoun deployment was identified as one particular technique that was used to attend to potential challenge or undermining of the speakers' claims.

Analysis has also demonstrated that participants' deployment of 'we' is variable and can be seen to accomplish a number of different actions. In terms of sharing treatment decisions the action-orientation of first-person pronoun use was seen to perform three different activities: prevent patient involvement in the decision making phase, encourage active participation and initiative taking by the patient and allow the patient to have some control over the agenda.

In the first part of the chapter, it has been shown how the use of the term 'we' helped to paint a picture of inclusiveness and partnership that masked the rhetorical persuasiveness of pronoun deployment. As a result of this, a power imbalance in favour of the doctor or the medical agenda was maintained. One reason offered to account for this relates to the referential ambiguity of 'we'. It was shown that it is seldom clear who the referents of 'we' actually are when doctors deploy 'we'. When the doctors used 'we' it could not be assumed that the 'we' use actually intended 'you and I'. 'We' may

refer to colleagues, the GPs practice or even more global. 'We' could be working as the 'voice' of the health service. The doctors' deployment of 'we' was seen to permit the medical agenda to take precedence over the patients' agenda and was seen as an effective discursive strategy that worked to invite consensus, and prevent patient involvement without imputation of coercion.

The second part of the chapter described how the opposite could also be observed. In Extract 4 the doctor was seen to invite patient involvement and offered the patient both the time and space necessary to accomplish this. In this extract the doctor seldom used 'we' and instead used 'I'. Here it was noted that using 'I' prevented ambiguity, and this appeared to have more success in terms of involving the patient in the negotiating and sharing of treatment decisions. The patient was offered direct choices and was left to decide for herself whether to take them up or not. These choices may have been small and perhaps not life-changing but ultimately showed that the patient took a more active role in the consultation. There was little evidence to suggest that the participants were orienting to issues of personal stake. The discursive strategies and resources in play were seen to help prevent the construction of a 'controlling' doctor and instead, a conversational trajectory was constructed that facilitated greater patient involvement and, thus led to a more symmetrical balance of power.

In extract 5 an unusual interaction was seen to take place. The patient used 'we' on several occasions. There was no referential ambiguity when 'we' was used. Here, when the patient said 'we' it was clear that he/she intended 'you and me, doctor'. Using 'we' allowed the patient to take the initiative to a degree not seen elsewhere in the dataset. For this patient the deployment of 'we' essentially worked to challenge the doctor's

agenda and as a result allowed the patient to have some control. The interactional opportunity for patients to take control of the agenda is likely to be something of an exception. However, the analytic reading may provide practical information on the ways participants can be taught to have a more active role in attending to their agendas.

In more practical terms, consultations where pronoun use appeared to facilitate patient involvement tended to be longer. It may well be the case that 'time constrained' doctors have developed discursive strategies using 'partnership' talk that reduces resistance or invites consensus that help to get the job done in time. Some of the analytic reading may also point towards an explanation for non-compliance i.e. why patients 'say' they will adhere to treatment when speaking with the doctor but don't follow this through. Doctors may hear agreement that is in fact not the case (i.e. no comment may provide an inference of agreement). Understanding the negotiation phase at a locally discursive level has revealed that pronoun deployment is rhetorically powerful and persuasive. This examination may have helped to identify a key aspect of this style of treatment decision-making.

Analysis has illuminated the variability found in the construction of accounts and the action-orientation of first-person pronoun use in the consultation. It has also identified that the potential benefit of using 'we' and 'us' talk to facilitate sharing will be undermined if patients are not given the opportunity to respond immediately and directly to the treatment proposals from doctors. The use of 'I' by doctors was also seen to vary in its functionality, for example, 'I' was also found on occasion to be both conducive to partnership and sharing and could also work to undermine the patient. In

this chapter it was found that the participant who used 'we' was the one who held control and power at that time.

This chapter has identified only one view of power. It has highlighted how power was discursively constructed and how this power was seen to impact on the interaction at a localised and situated level. Here the nature of power was manifest in the conversational flow and trajectory. There are other ways to examine power however, and, it is necessary to briefly acknowledge how other interpretations of power can be seen as relevant to the interactions within the consultation.

In broader cultural or symbolic terms power is claimed to always operate in conditions of unequal relations (Hall, 2001 p339). Doctors are seen to hold the position of power by virtue of the knowledge they possess in terms of the medical, technological and professional status that being a doctor provides. Following Foucault, Hall (2001) argues that both the victims and the agents of power are enmeshed within its field of operation. Thus, outside the situated activities from within the consultation there exist asymmetrical relations between doctors and patients.

Here power is seen in terms of knowledge. What is thought to be 'known' by doctors (and patients), is seen to have a bearing on how doctors operate within the medical setting (both in terms of the art and science of medicine). For example, the knowledge held by doctors, about disease and illness and population health and economic cost, will assume an authority of truth and, from a Foucauldian perspective, this will also have the power to become true, whether or not it has been proven in absolute terms. This knowledge is seen to regulate the conduct of others and discipline practice. For

example, screening and inoculation practices may or may not lead inevitably or directly to better population health. However, if everyone believes that these practices do lead to improved national or global health, the practices will be encouraged and the beliefs will then become true in terms of its real life effects.

The aim of the dialogue above is to highlight how some interpretations or representations of reality can become dominant modes of knowledge. One question to ask is, if asymmetry is unavoidable and immutable then is there much point in SDM? Indeed, can SDM actually be accomplished? To take this perspective would be to adopt a realist mode of discourse and look for 'knowns', where power is seen to stand-alone and possess a sense of 'out-thereness'. The difficulty would be in pointing to where power is in the actual talk.

The alternative to this approach is to take a more relativist perspective by looking at how discourses of 'knowing' are put to use. This is what this study has aimed to do. Although it may always be an implicit concern, it is not the job of this thesis to debate the issue of whose interests are best served by the dominant representations. It is simply important to acknowledge that the broader power issues should not and cannot be easily separated (or remain invisible) from within the localised nature of the consultation.

In conclusion, through an examination of how participants accomplish a 'shared-decision' this chapter has shown that the balance of power remains asymmetrical. In part, this is done through the construction of partnership, which is underpinned by pronoun deployment.

CHAPTER SIX

The Rhetoric of Requests

6.1 Introduction

As the 'requesting' behaviour of patients is more likely to be present in patient-centred consultations (as opposed to doctor-centred consultations), analysis is warranted in order to explore and describe the discursive formations of this event. In this dataset there were a significant number of occasions (11/30 consultations) when patients made direct requests in the consultation, usually in response to the doctor's opener, e.g. "what can I do for you?" This chapter is concerned with the identification and exploration of the features found in the construction of successful and unsuccessful requests.

The first part of this chapter presents three extracts from consultations where patients had asked for particular specialist treatments. Next, doctors' responses to being asked outright for certain resources or treatments are examined. The final section describes the analysis of two longer extracts. The first of these is taken from a consultation where a patient's request is refused and in the second, a patient asks for anti-depressant treatment that is granted, but only after the construction of an elaborately co-constructed socio-medical case.

6.2 Warranting requests

Extract 1 is taken from the beginning of a consultation where the patient reports having a hearing problem and wants the doctor to establish whether or not the problem is serious or not. The inference made available here is that if the GP cannot attend to treatment, then referral to the specialist is necessary.

6.3 Extract 1D5ARF 'The major-minor construction'

1. Dr: Good (.5) Right (.) S:o what can I do for you
2. Pt: Em (.) I've got a hearing problem
3. Dr: (.5) Right
4. Pt: (.5) So what I'm here for is to find out if it's a real hearing
5. problem or whether it's wax or fluid in the ear
6. Dr: Ok:ay (.5) How long has this been a problem

This extract begins with a conventional opener from the doctor "*So what can I do for you?*" (L1). The form and structure of this utterance works to inform the patient that the doctor is getting down to business. The patient's response is direct and 'factual' "*em I've got a hearing problem*" (L2). The patient's response is formulated to be unchallengeable, and the directness helps to resist potential undermining over the facticity of the claim and provides a sense of immutability. That the patient has a hearing problem is accepted without challenge by the doctor's response of '*right*' (L3) and works to reinforce the 'matter of factness' of the problem. The patient continues to be specific and essentially informs the doctor of his/her expectations by directing the doctor to the particular areas to be addressed "*So what I'm here for is to find out if it's a real hearing problem or whether it's wax or fluid in the ear*" (L 4-5). This talk informs the

doctor that the patient is aware of and understands that there are, potentially, a number of reasons that could account for the hearing problem. This provides the patient with a degree of authority, possibly not traditionally expected of patients, and may work to provide some equal footing between participants by reducing any potential imbalance between the GP's knowledge base and that of the patient's. Warranty is given to the request when the doctor says, "*Okay, how long has this been a problem*" i.e. the authenticity of the hearing problem and the need for a diagnosis is not contested in any way.

The talk in lines 4-5 can be viewed more as a typical example of what the doctor might say or offer to do as opposed to what is being done here. That is, here the patient is suggesting what should be done. This opening sequence provides an example of a patient who has taken the lead and informed the doctor of what he/she expected from the consultation. The second feature of interest in this extract is with the formulation of the problem as being an either/or in terms of it being a major (real hearing problem) or a minor problem (wax in the ear). Here the legitimacy for consultation is presented in terms of the presentation of lay knowledge of symptoms, which require medical expert verification. With this formulation the patient has set the agenda for the doctor to attend and has also set the parameters for the doctor should it be found that wax in the ears is not responsible for the hearing problem (the implication being that the condition is more serious and outwith the GPs remit and will require specialist investigation).

This extract has identified a patient's request that has been constructed successfully to prevent it from being challenged. The patient essentially sets up the issue from the start as one of legitimate medical diagnosis in terms of uncertainty: it could be minor but

then again it could be a more serious problem requiring further investigation. It is the presentation of this lay uncertainty that works and provides a rationale for seeking a consultation. The request is accepted without resistance from the doctor and does not require any 'negotiating'. The patient's implicit request has not given the doctor much space to suggest any other option. The remainder of this consultation was taken up with the doctor examining the patient's ears as implicitly requested. Finding no evidence that the problem was the result of wax, the decision was made to refer for further investigation.

The 2nd extract comes from a consultation where the patient makes a direct request for a referral to dermatology. In order to support the request the patient provides the doctor with a chronological history of the present concern.

6.4 Extract 2 D6ARF'Warranting request with attention to a problem'

1. Dr: Now wh:at can I do for you:
2. Pt: Em loads of things (laughter) hopefully
3. Dr: Okay
4. Pt: First of all em could you please refer me to dermatology
5. Dr: (Mh:mm)
6. Pt: (for my) face it looks as though it's okay just now actually (laughter)
7. Dr: Yes
8. Pt: (but em)
9. Dr: (What) problems are you having with your (.) it
10. Pt: Well since I was eleven I think about eleven when I first
11. started just normal
12. Dr: (Yeah)
13. Pt: (teenage) skin and they says "oh it's just a phase and you'll grow
14. out of it" (and)
15. Dr: (You're sick of it)
16. Pt: (I'm twenty one) and although Yeah really like really
17. em it's (.) it's like a main well it seems to the main thing that the
18. only thing I ever worry about or that bothers me or that don't know
19. it's just always an issue.

As in the first extract, the doctor's opener is seen to provide an opportunity for the

patient to be specific about what he/she expects from the consultation *"Now what can I do for you?"* (L1). In this case, after responding with *"em loads of things hopefully"* (L2) the patient makes a direct request to be referred to dermatology *"First of all could you please refer me to dermatology?"*(L4).

The descriptive history of the condition is seen to attend to a potential undermining within the doctor's question *"What problems are you having with your... it?"* (L9). The patient responds with a reference to the 'age of onset' *"Well since I was eleven I think about eleven when I started"* (L10-11) and later says *"I'm now twenty-one"* (L16). By specifying the age when the problem first occurred and reporting that he/she is now 21 years old the patient leaves the doctor to be the judge of the chronicity of the condition (with the implicit suggestion that the condition has been around for ten years). This works to avoid making a direct and possibly inaccurate claim that the condition is always there and also presents a claim of being long suffering. Not only does the patient's report provide mitigating factors for specialist intervention, the patient has implied that the condition has not been taken seriously and suggests that it has been dismissed in the past as something transitory and expected *"just normal ... teenage skin"* and *"oh it's just a phase and you'll grow out of it"* (lines 11-14).

Potter (2000, p3) has reported it is not the general pattern of events so much as the detail that makes a story credible. The detail provided in this chronological accounting has a number of actions. First it helps to construct an account that is convincing and so will be difficult to undermine. One of the ways this is achieved is by 'setting the scene' or 'painting a picture' in such a way that works to claim the occasion or event described or reported was 'reality' and not simply invented or embellished. In this extract this is

accomplished because the patient's detailed history of the condition serves to provide warranty that the patient is a believable and proper witness to the events he she is describing. Detail works in this case by constructing the condition as a medical history that has not been resolved so as to construct the patient's request for the legitimacy of the condition as a chronic one to be acted upon i.e. as one requiring resolution and a sense of closure through specialist diagnosis and treatment.

It is clear that the patient has oriented to a potential refusal or rejection in the doctor's question (L9), and the descriptive account is formulated to address this. Potentially there are at least two issues at stake for the patient with regard to the granting of the request. First, just because the patient has asked for specialist intervention will not alone guarantee it will be provided. To ask directly for something runs the risk of outright refusal, as asking could be culturally viewed as bad manners or rudeness. It has been reported that when making a request vagueness may actually work better to prevent any inherent claims from being rejected as it is harder to reject a request if it is only implied (Gill et al, 2001). As the patient had been direct, the potential granting of the request may have been weakened.

The second issue for the patient relates to the absence of visible evidence of having a skin condition. The doctor's question may have oriented to this. As there are no visible signs, the legitimacy or 'doctorability' (Stivers and Heritage, 2001) of the request could be questioned. Normally, visible skin problems would stand alone in countering legitimacy issues when making a request for a particular treatment or service (indeed, there would be no legitimacy issues at stake as it would be a case of 'seeing is believing').

Attention to the doctorability issue is brought to bear after making the request with the utterance *"for my face it looks as though it's okay just now actually"* (L6). This construction works as an offensive rhetorical device. By stating that the doctor will not be able to 'see' the skin condition, the patient provides a counter for a potential rejection of the request as unwarranted. This 'getting in there first' approach and bringing a potential legitimacy issue to the fore, places the patient in a stronger position to ward off challenge. In other words, the patient's utterance (L6) has already worked to prevent undermining of credibility surrounding the request. Although the patient constructs the request using an offensive rhetorical strategy to deal with legitimacy issues, the accomplishment of a successful granting of the request is unlikely without further justificatory accounting. This was assisted by the presence of laughter (L2 and L6).

Laughter has been recognised as a discursive resource that does not simply function to provide humour within the consultation. It is often used when patients want to correct the doctor's understanding of their explanation or concerns relating to the instructions or advice the doctor is providing i.e. as a remedying or legitimising device (Haakana, 2001). In line 2 of this extract the patient can be seen to be preparing the ground for the request by orienting to a forthcoming delicate issue that is later found to relate to the legitimacy or 'doctorability' of the presenting condition.

A further feature to strengthen the patient's request is a discursive strategy described as active quoting or active voicing (Potter, 1996). This is found in the following utterance *'they says "oh it's just a phase and you'll grow out of it'* (L13-14). In this sequence active voicing serves to downplay the patient's agency by introducing an external agent

and also shows that what was said had been accepted but that 'growing out of it' had not in fact transpired (L13-14). In addition, words such as 'they' and 'them' can also be rhetorically persuasive and work to strengthen a claim. When not using a specific figure or number, vagueness reduces the likelihood of the speaker being challenged on the accuracy of the claim made. Here it provides ambiguity, leaving the listener to decide on the degree of consensus. In line 13 the active voicing serves to provide a claim for the 'truth' of how wrong 'they' were. The patient does not say who the referents of 'they'. By not being specific it becomes easy to hear 'they' as a reference to a *"general experience of a range of people"* (Potter, 1996). Potter describes the use of active voicing as a powerful tactic for preventing a claim being undermined on the grounds of reservation or scepticism. This discursive activity helps to emphasise the primacy of others' beliefs as if the use of others' words can provide extra strength to a claim. According to Potter, the rhetorical power of active voicing *"brings into being separate corroborating actors who, like ventriloquists' dummies, seem to have life, opinions and personality of their own"* (Potter, 2000 p161).

In this extract active voicing is rhetorically successful in countering potential challenge on two counts. First it prevents any dispute over the accuracy of the claim and second it strengthens warranty for the request. This device has been described as basic to lay reasoning relating to consensus and corroboration, and its deployment can show how consensus and corroboration is not simply a thing that is done whilst constructing objectivity and facts, but that it is managed and worked up as a result of the construction of claims (Potter, 2000). This rhetorical feature works in terms of the implication of how others' perceptions are presented as being accepted in good faith at the time but

then become subject to question and doubt as time has passed and the condition has remained.

Analysis of Extract 2 has identified that the patient has formulated a justificatory account to warrant a request. This account is constructed to counter a possible refusal to deal with issues relating to the doctorability of the condition and, orient to the potential for the request to be viewed as unwarranted or unnecessary. Analysis has described how the business of formulating a successful request is clearly complex. A variety of devices and strategies were deployed to help strengthen the claims underpinning the request, provide warranty for a specialist referral and head off a refusal. These kinds of discursive activities have shed light on how requests, being open to a potential 'no' response, are rhetorically packaged to accomplish a 'yes' response.

Extracts 1 and 2 have shown how patients construct successful requests. In the first extract matters were formulated in terms of a major (potentially requiring specialist referral) or minor (potentially something the GP can attend to locally) condition. The construction was set up in such a way that the parameters were already set out for the doctor. As a result the patient had little work to do in accomplishing a successful request. In the second extract the patient had a lot more work to do to ensure the request was granted. Here it is seen that the patient oriented to an issue of legitimacy over the lack of observable signs of having a skin condition. One feature of interest common to both extracts relates to the fact that the diagnostic work was essentially done by the patient (albeit set up as a lay diagnosis requiring expert confirmation). Both patients had informed the doctor of their expectations in direct ways. This directness enabled these patients to play an active role in the decision-making.

The following extract provides a further example that shows how people can work up corroboration for their claims using other available discursive strategies and devices. The extract begins again at the start of the consultation.

6.5 Extract 3 D1JLF 'The virtual presence of a mother'

1. Dr: I haven't seen you since before my holidays I
2. don't think
3. PT: Quite a while
4. Dr: Quite a while yeah
5. Pt: I have got four things I want to ask you
6. Dr: Ok:ay
7. Pt: First is I have got a mole on my side that keeps bleeding
8. Dr: Ok:ay
9. Pt: and mum said I'd better get that checked out (.) em (.) because
10. I have got a lot of moles

The doctor begins with a comment that implies he/she has not seen the patient for some time *"I haven't seen you since before my holidays I don't think"* (L1-2). This comment is quite specific as regards temporality. There are two points of interest with this comment and the patient's subsequent response. First, the patient does not simply agree with the comment and replies with *"quite a while"* (L3). Unlike the doctor's specific reference to some kind of time frame, the patient's response is vague and does not make clear a specific length of time. This vagueness can be seen to prevent a potential claim of inaccuracy whilst working to imply a sense of extended or considerable time since the patient's last visit. This response may serve to prepare the ground for the patient's next utterance, *"I've got four things I want to ask you"* (L5). The 'quite a while' remark provides an unspoken claim that the four concerns have risen during the intervening time and thus will provide some justification for bringing them all on one visit.

The doctor grants the request with 'okay' but the patient responds to this with further warranting. What appears somewhat unusual here is that the patient appears to be orienting to a doctorability concern *"and mum said I'd better get that checked out because I have got a lot of moles"* (L9-10). There should be no 'doctorability' issue with the request to get the mole checked out as it is bleeding. It would seem appropriate to make the assumption that a bleeding mole will be recognised by most as requiring investigation. The question to ask is why does the patient deem it necessary to provide a kind of external corroboration and what does this do?

It appears that the patient continues to orient to the problem for the consultation of bringing a list of things to the doctor. Raising the first item performs two actions. First it identifies the primacy of this as the most important concern, and secondly, it is raised as a concern of another agent (and not just any old agent but one conventionally associated with care and concern). This may work to strengthen the request and limit the patient's personal responsibility for bringing four concerns along in one visit (and may be orienting to the implicit issue over consultation time).The patient reports that his/her mother had said that the mole needs checked out. The point of interest here is that the patient does not report it is he/she who wants this. Rather, the implication is that the patient was 'advised' by another and not just any other. It was the patient's mother. The patient has utilised what has been described as a membership categorisation device (MCD)[16]. Personal categories such as 'mother', 'father', 'son' or 'daughter' are described as membership categories (MC's). Furthermore, they are viewed as categories of the MCD 'family'. An MCD is seen to encapsulate a shared 'stock of commonsense

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[16] *Membership categorization device* "any collection of membership categories, containing at least a category, which may be applied to some population containing at least a member, so as to provide, by the use of some rules of application, for the pairing of at least a population member and a categorization device member. A device is then a collection plus rules of application" (Sacks, cited by Silverman, 1998, p. 79).

knowledge' (Sacks, 1972a) associated with certain cultural activities. Bringing 'mum' into the picture is drawing upon the membership category of ' mother' and in this context is made to work as a means of justifying the raising of the mole as a medical concern. Mothers are conventionally associated with being concerned for the welfare of their children, particularly in terms of emotional attachment. They are also part of an authority or advice relationship between parent and child that is different from other relationships e.g. a friend. Here, the situated use of this social category trades on these features in terms of an inferential resource. This strengthens the warranty for the request for investigation. In addition the issue of concern is raised through particularisation. The patient has reported a number of moles but it is the one that keeps bleeding, i.e. with the inference that this is not just a one off but also a continuing problem, which again legitimises seeking a consultation about it. This brief analysis has presented a variation in the discursive strategies and devices deployed to make legitimate and corroborate the patient's request to have a bleeding mole investigated. Here the mother was used as an external agent to provide further warranty for the request.

In sum, analysis of three extracts has identified and described a variety of discursive strategies that have helped to construct warranty for patients' requests. In the first of these the patient had constructed the concern as a major-minor problem for the doctor to attend to. This made it difficult for the doctor to suggest a different treatment option to those that were implicitly set up by the patient. In the next extract, the patient's request introduced a problem i.e. no visible evidence that could endorse the request for specialist investigation. Here a number of strategies were used to legitimise the request. These included justificatory accounting, laughter and active voicing. In the third extract an external agent, the patient's mother, was deployed to aid the warranty for the request.

An additional device of 'particularisation' was also deployed here to further strengthen the warranting. What has become clear is that the deployment of these different discursive resources indicates that patients orient to the potential of doctors taking up opposing positions and (in effect refusing requests) so their discursive activities are used to attend to this potential undermining. Additionally, patients may also be orienting to the other issue of GPs being the gatekeepers to specialist referrals and therefore, they may have to work harder at requests.

Whilst these extracts have so far examined direct requesting behaviours of the patient, there has been perhaps less attention given to the doctor's responses, e.g. the agreement or refusal of the request. The next extract is presented to illustrate and describe some of the variability found in doctors' responses. Extract 4 was selected because the request was unusual in the sense that it did not seek out a particular medical treatment or intervention. Instead, the doctor was asked to make a decision on whether or not the patient should go to work that night. The talk continues from a point after the doctor had attempted to draw the consultation to a close.

6.6 Extract 4 D5CBF 'Passing the buck'

1. Pt: So do you think I should go in tonight or
2. Dr: I would probably: well (.) it's a difficult one (.) how do you feel (.) where
3. are you working
4. Pt: South Park
5. Dr: South Park
6. Pt: Hell of a busy ward (.) not that I'm trying to cop out but
7. Dr: Yeah I know (.) If you're not feeling right you're not feeling
8. right (1.) at the end of the day (1.5) I'm sure they would find somebody
9. if you were:
10. Pt I here's there's loads on I would have phoned really (.) earlier if I'd
11. have thought but (distinct drop in tone and volume from this point until 1.16)
12. there's loads on they won't really be short
13. (2 sec pause –noises of rustling paper) sometimes: (.) I suppose if I don't

14. (feel ok I could come home)
15. Dr: (Mhmm see how it goes) (quietly spoken)
16. Okay thanks for listening to my moans on a busy day.
17. Dr: That's okay. No problem. Bye now.
18. Pt: Bye

Earlier in the consultation the patient had reported having flu-type symptoms and these were duly discussed. However, the patient had not asked about whether or not he she should go to work at this time. It is reasonable to conclude from the above sequence that the patient's agenda had not been dealt with completely prior to this point. Both participants have a delicate situation to deal with. The patient has reported having symptoms of flu. Line 1 shows the patient asking the doctor a direct and closed question. At first the doctor appears to be about to provide a direct answer *"I would probably"* (L2-3) but this utterance is brought to a halt. The doctor is not directing as he/she stops off from saying what he/she would 'probably' do. The repair to the utterance suggests that this has become a rather sensitive or delicate issue for the doctor too. Indeed, there is an open acknowledgement that *'it's a difficult one'* and it appears that the doctor is stopping short of giving a direct yes or no answer. Without the repair the decision-making would have been taken away from the patient and been done by the doctor. Instead, the doctor continues by asking two questions that effectively redirect the decision and agency back to the patient and by doing so the doctor does not make the decision on the patient's behalf.

It is likely however that the doctor is doing more than simply declining an 'invitation' to make a 'decision'. Rather, the doctor's talk works to refuse to give the patient direct 'permission' to stay off work. The warrant of a medical authority is being withheld and the agency for the decision to stay off is placed with the patient. The doctor's response

can be described as a 'dispreferred' response[17] (Sacks and Schegloff, 1979) and here it is seen to perform the action of an implicit refusal to an implicit request. It has been reported that when a refusal is on the cards, speakers are unlikely to say 'no' directly. In the examination of mundane conversation it has been shown that refusals are seen to take longer, have more pauses and repairs and are often protracted. On the other hand, when accepting an invitation the response will be immediate and direct (e.g. Kitzinger and Frith, 1999). Here, the doctor's response is rather lengthy and 'considered', bearing in mind that the patient's closed question was constructed to elicit a direct answer. The repair and reformulation (L2-3) serve to counter unfavourable personal attributions for the doctor and at the same time externalise responsibility. Of course, the same could be claimed for the patient's request. The patient can also be seen to be attending to a similar issue by constructing the question in this way (using a face-saving device in not saying he/she wanted to stay off work prevents rejection) and also attempts to externalise responsibility for the decision. The patient responds by providing the information requested in the doctor's second question *"where do you work"*. After the doctor repeats the patient's answer, "South Park" (L5), it becomes apparent that the patient did not view this repetition as affirmation. Rather, it was heard as a statement that called for further expansion. The next utterance is seen to indicate this *"Hell of a busy ward not that I'm trying to cop out but"* (L6). The word 'Hell' makes an implicit claim it is much more than just an 'ordinary' busy ward and leaves the doctor to make judgements over the patient's 'fitness' for work. This talk provides implicit extenuating circumstances in order to justify the earlier implicit request for permission to stay off work. Further, the patient informs the doctor that he/she is not trying to 'cop out'. This

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[17] Conversation analysts report that when invitations are made the 'preferred' option is acceptance and the 'dispreferred' option is rejection. NB. 'preference' does not refer to psychological desires or motives of the speaker but rather, relates to features of the actions themselves (Potter, 1996, p60)

comment provides an implicit claim that the patient is a particular type of person and one who would not be in the habit of dodging work.

Consequently, the doctor's response suggests the deployment of this rhetorically offensive strategy had worked and that the inferences in the patient's prior utterance were accepted with the comment *"If you're not feeling right you're not feeling right"* and *"I'm sure they would find somebody if you were ..."* (L7-9). Instead of accepting the acknowledgement and what was essentially mitigation for the patient should he/she call in sick, the patient's next response suggests that there is still a problem as the patient continues to pursue the matter with further justificatory accounting.

As shown, the doctor's utterance in lines 7-9 did not provide the patient with an agreement or approval to report in sick. The patient returns to what appears to be an issue that still requires resolution (or absolution). It becomes apparent that the doctor's previous comment does not cover all of the patient's concerns. By addressing the lateness of the day with *"there's (.) there's loads on I would have phoned really (.) earlier if I'd have thought but"* (L10-11) identifies that the patient introduces another issue at stake that would have to be dealt with before he/she can accept the doctor's exoneration. It is around six o'clock in the evening and for those working in health care (indeed, anywhere for that matter) calling in to report sickness at this hour may be viewed as irresponsible if due to turn up for work around nine pm. It would be reasonable to conclude here that the patient has to deal with another dilemma. Not waiting for a response from the doctor, the patient is seen to answer the implicit criticism that he/she raised by suggesting a compromise could be reached i.e. saying he/she could go in to work but if necessary could come home if not able to work. The

doctor, however, does not clearly respond to this. The patient continues in a markedly lowered voice and in effect appears to be 'thinking out loud' and repeats that there are plenty of staff on and that the ward will not be short. As indicated there follows a pause in talk and the doctor appears to be attending to some paperwork and does not comment until after the patient 'muses' that he/she could go home if not able to continue at work owing to illness. The doctor replies in a similarly quiet tone, saying *"Mhmm see how it goes"* (L15). The patient orients to this comment as a topic closure by the doctor and begins to bring the consultation to a close with the utterance *"okay thanks for listening to my moans on a busy day"* (L16).

This extract has presented an example of a complex negotiation of a delicate situation affecting both participants. To take time off sick when the doctor has not actually advised this leaves the patient in a difficult position. Whether or not legally required, permission from the doctor to stay off work may be more socially acceptable. However, the construction of the patient's attempt to seek this form of legitimacy was not achieved. Essentially analysis has shown that a 'direct' and pointed appeal for the doctor to make a decision alone and say whether or not the patient should go to work actually worked to mask a subtle request for permission to take time off sick. That is, the patient tried to get the doctor to use medical authority to remove the patient's agency in the matter but this was resisted and agency was passed back to the patient (the issue of sick lines may be a delicate issue for GPs given that it moves beyond the medical matters *per se*).

Although this extract has identified a consultation where the doctor's talk was constructed to accommodate the patient in the decision-making process this was again

found to be an uncommon feature in the dataset. The next set of extracts describes occasions where the doctors, when presented with multiple requests, choose what is to be discussed first. In extract 4 the patient offers two reasons for the visit, acupuncture treatment[18] and a review of HRT[19].

6.7 Extract 5 D2LMF 'Tangents, trajectories and temporality'

1. Dr: So what can we do for you
2. PT: Well it's my last acupuncture session and I wonder if you
3. could sort of check me over because I've been on the (.) em (.) pill
4. again (.5) the HRT for about two months
5. Dr: Right (.) okay (.5) It's been a w:ee while since the last
6. acupuncture isn't it
7. PT: I know (.) you were away and then I was away and:
8. Dr: How do you feel things have been
9. PT: Em (.) what's the pain score again (.5) ten being the wo:rst
10. Dr: Yeah.
11. PT: Ahhh (.5) three maybe.
12. Dr: So is it (.) has it maintained it quite well (.) has it
13. PT: Yes (.5) Rea:lly rea:lly much so (.) Yes
14. Dr: Good (.) Okay.
15. PT: Only really painful if I'm really over (.) you know (.) if
16. I do a lot of walking.
17. Dr: And the medication wise at the moment (.) as far as pain
18. killers are you still taking (the)
19. PT: (the) Co-proxamol
20. Dr: The Amytryptiline
21. PT: Yes
22. Dr: Both (.) that's the 50 and the 25:
23. PT: Yes
24. Dr: at night (.) and then what about the Diclo:fenac
25. PT: Diclofenac (.5) Yeah (.) I take that twice a day.
26. Dr: That's with the stuff with the tummy protector in it

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[18] The patient is receiving acupuncture to treat chronic pain.

[19] HRT refers to hormone replacement therapy. This is medication that is prescribed for symptoms of the menopause. Some kinds of HRT have a much greater effect on a woman's risk of breast cancer than others. The Million Women Study, funded by Cancer Research UK, the NHS Breast Screening Programme and the Medical Research Council, confirms that current and recent use of HRT increases a woman's chance of developing breast cancer and that the risk goes up with duration of use. Current users of all types of HRT, including oestrogen-only, combined oestrogen-progestagen and tibolone, are at increased risk of breast cancer compared with women who have never used HRT. But the risk is substantially greater for users of combined preparations of HRT than for women on the other types. Source: http://www.cancerresearchuk.org/news/pressreleases/HRT_breast_cancer_08aug 2003

27. PT: Yeah
28. Dr: And you take tha::t as well
29. PT: Yes
30. Dr: Still think you need a:ll of that (.) I'm just wondering (.) I'm just
31. thinking from your point of view (.5)
32. PT: Yeah (.) Em (.5) I don't take the Co-proxamol a:ll the time now
33. Dr: Fine (.) right.
34. PT: Sometimes I just take one depending what sort of day it's
35. going to be:
36. Dr: and the others a:re regula:r which is the way it shou:ld be.
37. PT: Yes (.) Yes
38. Dr: That's fine (.5) Okay (.) Em (.) and the HRT (.) t: t: t: that's the
39. Pre:ma:rin is tha:t right

The patient is invited to tell the doctor why she is visiting *"So what can we do for you?"* (L1). As reported in the previous chapter the deployment of 'we' is often ambiguous. Here it works to de-personalise the doctor, with the 'we' working as a collective voice. The patient reports she has two items to be addressed (L2-4). There is no reason for the doctor not to deal with the HRT issue first unless it was simply a matter of the acupuncture being mentioned first. Nonetheless, the subsequent review of the patient's pain management could possibly have been left until during the acupuncture treatment. Thus, there does not appear to be either a medical or practical concern dictating the doctor's decision. The response *"Right, okay it's been a wee while since the last acupuncture isn't it"* (L5-6) is also ambiguous and may not even directly acknowledge the patient's request for the HRT review. The 'wee while' is contradictory and works to imply instead that it has been 'some time' since the last acupuncture treatment. Whether or not the patient expected a review of the pain management on this occasion the HRT has been relegated to second place. Unlike the previous extract the doctor's talk does not function to include the patient. Here, the doctor's comment works to close off the potential for negotiation and the decision over which item should be dealt with first has been taken.

The extract indicates that the items on the patient's agenda are expressed in different ways. The first item on the patient's list was said as a matter of fact, it was not constructed as a request but more of a statement *'it's my last acupuncture session'* (L2). The implication being that as this is the 'last' acupuncture treatment it is practical to raise the 'new' concern at this time instead of arranging another visit, thus providing subtle warranty for the forthcoming request. This request was raised more hesitantly *"I wonder if you could sort of check me over because ..."* (L2-4). The differences in the formulation of these two utterances suggest that the patient did not expect to have to account for the acupuncture treatment but did expect to provide justification for her request.

The HRT review request (L2-3) is constructed in a delicate and indirect way. The *'I wonder if'* and *'sort of'* is vague and does not import assertiveness. This formulation can be seen to attend to the potential for refusal because it has been constructed as undemanding. The request also contains an explanation *"because I've been on the pill again, the HRT"* (L3-4). Providing an explanation at the same time as making the request suggested that the patient has oriented to a potential problem and the explanation provides a justification. The doctor's response to this was ambiguous. It is not clear whether the *'Right, Okay'* (L5) was in fact an agreement or if it was used more as a strategy to get down to business. There is no explanation for the decision and the decision-making by the doctor appears to set the pattern for the remainder of the sequence. The doctor's follow-on utterance (L5) appears to be heard as an attribution of blame as the patient is seen to account for the 'wee while' by stating *"I know, you were away and I was away and"* (L7). The doctor's response to this comment is to interrupt the patient and change the topic (L8), and the patient is restrained from further

expansion. The doctor repeats these activities when the patient begins to describe her pain (L15-16). The doctor does not take up the patient's comments and another topic shift occurs.

There follows a review of the patient's current medication regime. The patient is required to respond to some quick fire questions relating to analgesia (L17-29). What is seen to occur in this sequence of talk is that the space for the patient to provide expanded answers is closed off or limited. When the patient provides the name of the medication (L19) she is corrected and her suggestion is treated as erroneous. After being corrected the patient responds to the further questioning with only 'yes' responses.

The doctor continues by questioning the patient's use of the analgesia. It should be noted that the medication the patient is on was prescribed and the patient is not exceeding the dose. However, the formulation of the doctor's questions makes available particular inferences in order to imply that the patient may not need so much analgesia and that it should be reduced. This raises a delicate matter for the participants because it may be taken up as questioning the patient's ability to know for herself whether or not she is taking too much medication. Finally, the doctor asks, *"still think you need all of that?"* (L30). The implicit allegation is now out in the open but formulated in such a way as to avoid imputing that this is the doctor's view.

Having asked this question the doctor does not wait for a response and continues with *"I'm just wondering I'm just thinking from your point of view"* (L30-31). This works to reinforce the absence of the doctor's personal judgement by appealing to his/her integrity. By adopting a personal and attentive 'voice' the utterance works to remove the

voice of medicine. The patient responds with *"I don't take the Co-proxamol all the time now"* (L32) and in spite of the doctor's acknowledgement *"Fine, Right"* (L33) the patient provides further explanation with *" sometimes I just take one depending on what sort of day it's going to be"* (34-35). From these utterances it is apparent that the patient has oriented to the doctor's questions as some form of accusation that requires a response to account for it. She provides information that essentially aims to exonerate her from the implications within the doctor's questions. Again, the doctor is not seen to attend to take up the patient's comments and the justifications are left hanging. The next statement *"and the others are regular which is the way it should be"* (L36) is seen to close down further discussion and prepare for the forthcoming topic shift.

This extract has identified features of the doctor's talk that precluded full participation by the patient. The formulation of the questioning sequence left the patient with little space and thus control. On a number of occasions the patient was interrupted and changes in topic prevented her from expanding and allowed the doctor to move on. The analysis from this extract has shown that the routine business of performing medical reviews may leave little time or space for patient involvement.

In the following extract it is observed that the same doctor, faced with a similar situation, responds differently and does not make the decision on which item to address without first appearing to consider the patient.

6.8 Extract 6 D2CB3F 'Sharing the little things'

1. Dr: Wh:at can I d:o for you today
2. Pt: I got a message on my prescription to come and see
3. you (.5) I also wanted to see y:ou because I've been for an
4. eye test and I don't know (.) they found something (.)and
5. they wanted me to go and see a (specialist)
6. Dr: (Right)
7. Pt: (about) it
8. Dr: Is th:is the letter
9. Pt: That's the letter
10. Dr: Ah: r:ight (.) this is the letter.
11. Pt: Yeah
12. Dr: C:an w:e do the (.) we'll do the HRT first.
13. Pt: Yes
14. Dr: Is that alright (.) this is your usual check up for
15. your HRT
16. Pt: Yes
17. Dr: I'll leave this a second and it's the Tibilone

2.2.7.1 Part 1- Patient's warranting

Unlike the previous extract the doctor's opener here is more personal *"what can I do for you today"* (L1). This patient also responds with two reasons for her visit. However, the way in which the patient formulates the reasons for the visit accomplishes several different actions from those seen in the previous extract. First, the patient informs the doctor that she was 'told' to come in. She does not say what for, thus making available an inference that the doctor will or should know why. Consequentially, this removes the locus of responsibility for coming in with more than one item away from her. Having dealt with any potential problem (over introducing more than one item), the second reason for the visit begins with the patient informing the doctor that she also had wanted to see him/her. This invokes a picture of an assertive patient who is visiting the doctor not simply because it also happens to be convenient for her. The patient's reporting of

the reasons for the visit appears to have influenced the doctor's response to the vague request for consultation about her eyes. On this occasion it is seen that the doctor does give some consideration to the decision over which item to address first, *"can we do"* (L12). However, this request is reformulated into a command with *"we'll do the HRT first"*. The doctor's talk had begun as a request seeking permission, but the reformulation cancelled this out when it was followed with an instruction. Although the doctor started to present an opportunity that would have worked to include the patient in a (minor) decision the words *'we'll do'* ultimately function to instruct and direct and do not provide the patient with a choice in the matter. The patient is left to concur with the decision. Nonetheless, for some reason the patient's 'yes' response (L13) was not heard to provide absolute agreement because the doctor then asked, *"is that alright"* (L14). This checking for permission suggests that the doctor had oriented to a potential problem. It is possible that the doctor was checking that the utterance *'we'll do'* (L12) was not heard as commanding, and engaged in repair work that aimed to correct this potential impression.

In L14 the doctor is seen to ask a two-question sequence and as was identified in Chapter Four there is often ambiguity over which of the questions are being responded to. As a result doctors may erroneously accept the responses as agreements to their initial question or invitation. The same is seen here. In both utterances, *"is that alright"* and *" this is your usual check up for your HRT"* (L14-15) the patient's 'yes' response (L16) is taken to indicate agreement to both questions. Whilst it may actually be the case that the patient does agree with both questions, agreement may only be assumed.

This extract has illustrated some very subtle differences in the action orientation resulting from variability within how the opening phase of the consultation is formulated. Although perhaps (superficially) similar in content and form to the previous extract, it appears that this patient may have been more successful in securing space to be assertive. The doctor's personalised opener 'I' deployment may have aided this. Unlike the previous extract, here it has been identified that the doctor took up the patient's comments by asking permission and checking agreement.

The following extract provides an example of a patient's direct request being refused. The sequence of talk begins from the point where doctor returns to the patient's agenda with a reminder that there were four things to discuss. This sequence involves a complex interaction made more complicated by the presence of 'specialist' talk. Supplementary information relating to treatments for asthma is included below[20]. As this is a long extract it will be divided into two parts. The first section of analysis will describe the patient's warranting of the request and the second explores the doctor's grounds for refusal.

6.9 Extract 7D1JLF2 'When patients wonder'

1. Dr: You mentioned before that there were four things you wanted to
2. talk about
3. Pt: The second was (.) em I had an asthma attack and I had to go to
4. Perth Infirmary (.5) on Saturday (.5) it was Carol Smith that I saw
5. Dr: Right

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[20] *There are a number of drugs used to treat asthma in primary care and many can be administered using inhaler devices. Additionally there are a number of inhaler devices available that also have slightly different delivery systems. The first o, the two preparations discussed in this extract is'AeroBec'. This is a generic name for Beclamethasone (or becotide). This drug is a steroid that is prescribed to 'prevent' asthma. The second preparation, 'Salbutamol', is also known as Ventolin. This is a non-steroidal preparation that is taken to 'relieve' asthma symptoms. These drugs can be administered in a number of ways and by different types of inhaler devices. The inhalers referred to in the present extract are functionally similar. This information may offer some clarity for the next sequence of talk.*

6. Pt: and I mentioned to her that I was coming to see you on Monday
7. anyway
8. Dr: so she thought we should review you
9. Pt: Aha (1.) I was wondering if it would be possible (.5) to change the
10. Salbutamol inhaler that I am taking (1.) I am on the AeroBec at the
11. moment
12. Dr: Yea:h
13. Pt: I don't feel that works for me and I have got an Easy Breathe
14. inhaler as well at home that I have been using and I'm wondering if
15. it would be:
16. Dr: get the Easy Breathe
17. Pt: all right to change to the Easy Breathe
18. Dr: Now (1.) (rustle of paper) the AeroBec would be (.) er (.) wouldn't be
19. your Salbutamol (.5) it is (.5) is tha:t not your Beta:methas:one
20. Pt: Yeah (.5) they are both the same sort of inhalers that I have got
21. Dr: R:ight one's your pre:ventor and one's your reliever
22. Pt: Yes (.) uhuh
23. Dr: and the Easy Breathe will b:e your reliever so you wi:ll notice
24. an effect from that (5.) the other one you are n:ot going to notice
25. the effect b:ut if you are taking it regularly it is going to
26. prevent exacerbations (unclear speech) So let's just have a look (.) now the
27. AeroBec is one of the ones you br:eathe in (inbreath) it's an auto-
28. inhaler so you:
29. Pt: put up the lever
30. Dr: and (then you suck in)
31. Pt: (and you suck in)
32. Dr: so it is the sa:me so:rt of mechanism as the
33. Easy Breathe so there is none of this pushing down
34. Pt: N:o I've ne:ver had one that you push down
35. Dr: right (.) right so (3.) o:kay how many doses is that you are taking
36. Pt: (2.) th:e Sal:but:amol
37. Dr: the Aero::Bec
38. Pt: the Aero:Bec I'm taking four in the morning and four at night
39. Dr: Ri:ght
40. Pt: I have upped that be:cause I've been having a bit of (.)
41. problems because the field in front of us and the field behind us
42. (.5) they're both harvesting
43. Dr: they'll be harvesting yes so that is bound to (.5) so that is a
44. sen:sible thing to do I':d say (.) during the harvest (.) Em (.) so (.) er your usual
45. dose would be two doses twice a day and you have gone up to four twice
46. a day which (.5) i:s quite reasonable (.) er (.) I'm no:t convinced there would
47. be any (.5) you know (.5) em (.) mileage in switch:ing the preparation (.) em the
48. AeroBec at the right dose it might be (.) er (.) if you're getting more er (1.) (tisk
49. sound) symptoms we can a:dd in something else (.) but you kn:ow AeroBec (.)
50. seems to be the one you are (on)
51. Pt: (yeah right) okay (quietly spoken)
52. Dr: (It) is a reasonable dose and the way that you are taking it
53. the auto-inhaler is a (good:)
54. Pt (Am I) okay to get a repeat prescription for that because I will
55. be running out shortly (quiet speech)

At the beginning of this extract the doctor initiates the move towards identifying the second item on the patient's agenda. The patient responds by providing a detailed account of the background events before making his/her request known. As has already been stated accounts and reports, such as this one, are constructed to undermine or counter a real or potential challenge to claims made. The patient begins by setting up a case for a forthcoming request.

The justificatory account (L 3-7) has been constructed to do a significant amount of work to warrant the forthcoming request and it contains a number of features. It is informative, direct and detailed. The patient reports a newsworthy event. He/she has had an asthma attack that was severe enough to warrant hospital attention. Experiencing an asthma attack that requires emergency attention from a hospital can be regarded as a rather unusual occurrence. The patient's information makes available the inference that the current medication regime is not controlling the condition and so at minimum a review is warranted. Reporting an asthma attack should be enough to grab the doctor's attention but the patient is seen to add further warranty for the pending request.

The supplementary information provided, e.g., *"on Saturday"* and *"it was Carol Smith that I saw"* works to paint a picture of real events. Without 'factual' details of this kind the patient's account could appear at best vague and at worst simply made up or exaggerated. The reference to the actual day the emergency occurred also implies that the patient's memory of or the recounting of events will not have become distorted through time, as it is now only Monday. Further support is provided when the patient makes it known that he/she had already planned to come and see the doctor in any case. This works to imply that the patient had already raised the asthma treatment as a

concern without actually making a direct claim for this. This detail helps to construct a picture that the 'attack' was not a one-off and simultaneously will ward off any potential charge of factual inaccuracy.

Making known the attending practitioner's name highlights a further discursive resource. Instead of reporting that she was seen by 'a' doctor or nurse the patient identified the practitioner *"it was Carol Smith that I saw"* (L4). This 'name-dropping' strategy works to strengthen the forthcoming request as it contains an implicit corroboration for the patient's account that is difficult to dispute. The doctor responds with 'right' and the patient makes the request known *"I was wondering if it would be possible to change the Salbutamol inhaler that I am taking I am on the AeroBec at the moment" (L9-11).*

The doctor's emphasised 'yeah' response serves to cast some doubt over the request and seeks further information. The patient orients to this with the words *"I don't feel that works for me"* (L13). This utterance is seen to perform two actions. First it provides a justification for the request and second by stating that he/she only *feels* the treatment does not work provides the patient with a counter to potential criticism re factuality and accuracy of the claim. First the patient avoids stating a 'fact' that could be easily refuted and second, the doctor's medical expertise cannot be used to challenge how a patient 'feels'. The patient's request then is constructed to strengthen a case for refusal. This means the doctor will have to formulate a strong case if the request is not to be granted.

6.10 Part 2 - Constructing the grounds for refusal

After the request is made the doctor responds with what has come to be seen as a regular feature, i.e. presenting two consecutive questions, *"now the AeroBec wouldn't be your Salbutamol is it"* and *"is that not the Beclamethasone"* (L18-19). The first point to note in this response is the use of the word 'now'. In this dataset it is far more common for the doctor to use 'Okay' or 'Right' at this point, i.e. after receiving a direct request that was ultimately granted. In the extracts discussed earlier in this chapter there are no other examples where the doctor says 'now' when providing a response to a patient's request. As it is the first thing the GP says, the use of 'now' immediately marks this response as different and casts some doubt about whether or not the request will be granted. It is reasonable to conclude that the doctor's initial response to the request was formulated in order to deal with a potentially delicate situation in which the doctor deemed the request as somewhat tricky. Nonetheless, the doctor has to construct an explanation for the impending refusal that will be acceptable to both participants.

This utterance is formulated to portray neutrality and attempts to sort out the facts in a value-free way by constructing these comments as questions as opposed to statements of fact. It becomes apparent from the patient's response to the questions *"yeah they are both the same sort of inhalers that I have got"* (L20-21) that a misunderstanding or difficulty arises for both participants over various factors involved in the treatment for asthma. It is quite possible that when asking to change the Salbutamol inhaler the patient was not actually asking to change the preparation but instead the request may have been for a different delivery device. However, the patient's utterance was not initially oriented to in this way as the doctor proceeded to go over the various medicinal

properties of preventors and relievers (L21-26). Nevertheless, without comment from the patient the doctor moves on to remark on the delivery device "*So let's just have a look. Now, the AeroBec is one of the ones you breathe in. It's an auto-inhaler so you ...*" (L26-28). At this point the patient finishes off the utterance with "*put up the lever*" (L29). There are a number of features to note in this sequence of talk. First, the comment 'so let's just have a look' serves to import a sense of moving on and getting down to business, in this case, the unstated issue over delivery of the drug. Second, the doctor's deployment of 'now' is seen for the second time. However, unlike in L18, here it is followed with a statement as opposed to a question and, thus constructs a sense of facticity that successfully works to prevent challenge. Third, by finishing off the doctor's utterance, the patient indicates agreement with what the doctor is saying.

After the patient agrees that one inhaler is a preventor and the other is a reliever (L23) the doctor continues to provide details relating to the properties and effects of the current treatments the patient is taking. It is apparent from the sequence of talk (L27-46) the patient can be seen to be buying in to and agreeing with what the doctor is saying about the treatment issues and this works to strengthen the patient's implicit claims to knowledge and understanding. This is seen when the patient finishes off the doctor's utterances and supplements them with further information. The doctor is told that the patient has increased the Beclamethasone and warranty for this behaviour is given with a reference to mitigating factors i.e. harvesting. This works to prevent a potential claim that increasing the medication was irresponsible (L40-42).

The patient is told that his/her current medication taking behaviour is sensible and the reasonable thing to do (L43-44). This warranting is successful for the immediate

interactional concern but does not work to give strength to the original request. It appears that the patient's mitigation may have also worked to strengthen the claim for the following refusal *"I am not convinced there would be any you know em mileage in switching the preparation em the AeroBec at the right dose it might be er if you are getting more er symptoms we can add in something else but you know AeroBec seems to be the one you are on"* (L46-50).

There are a number of interesting features in this sequence. Here it is found that the first part of the sequence *"I'm not convinced there would be any mileage in switching the preparation"* works to let the patient know that the request is not going to be granted and following the rules of normative conversation a justification follows alongside. Although the doctor has not said no directly the formulation is packaged in such a way as to provide refusal.

Next, a metaphor is used to indicate there would be no (medical) benefit to be gained, 'no mileage in switching'. This illuminates a feature seen throughout the reviewing process relating to the combination of medical and non-medical talk. For example, 'preventor', 'reliever', 'exacerbations', 'dose' and 'preparation' are used amidst words such as 'lever', 'mechanism' and 'mileage'. What can be seen here is a deployment of different vocabularies. These vocabularies can be described as 'interpretive repertoires', which are *"systematically related sets of terms ... organized around one or more central metaphors"* (Potter, 2000 p116). Repertoires (or discourses) are reported to provide only generalised, inexplicit formulations of the actions and beliefs of the speaker. Gilbert and Mulkay (1984) explored scientists' discourses and found that they used the 'empiricist repertoire' when discussing their work. This enabled scientists to

formulate their reports as members of disinterested parties, forced to undertake actions by the demands of the natural phenomenon or the constraints of rules. Potter (2000) reports that empiricist accounting is seen to manage the dilemma of stake by directing attention away from the speaker and on to what is being reported. In this extract the repertoires of machine and medicine are used. These have two actions. First, they can be seen to help remove the doctor's agency by using, in a sense, other voices to do the work and second, serve to reduce the doctor's part in the refusal by re-directing it away from him/her and onto the 'machine'. To use Potter's words, the doctor "*becomes a passive responder to the requirements of the facts*" (p116). Incidentally, the different metaphors used fit together nicely and are rhetorically persuasive as the body is often regarded as a machine. The patient also buys into the metaphor.

Moving on, the doctor follows through with further justificatory accounting with the utterance "*the AeroBec at the right dose it might be er*". Implicit within this talk is a claim that the medication is not being used at the correct therapeutic dose. However, the doctor does not complete this utterance, nor is the utterance clearly repaired with the following one and the implicit claim is left hanging. However, by not completing the utterance, the doctor has formulated a claim that will be more difficult to refute, as he/she did not actually spell it out and it was constructed to avoid any direct imputation that the patient was not taking it properly. The doctor is seen to continue to manage a dilemma of stake. The refusal is not left to stand-alone. A kind of compromise is offered with the words "*if you're getting more symptoms we can add in something else*". Finally, the words "*but you know AeroBec seems to be the one you are on*" serves to remove the doctor's agency by implying that it is out of the doctor's hands.

As indicated in the transcript the patient was seen to lower his/her voice when responding to the refusal with *"yeah, right ok"* (L51). This response indicates that the patient is not going to pursue the matter. Nonetheless, it appears the doctor orients to an implicit dissatisfaction in the patient's response as he/she is seen to provide further warranting instead of moving on *"It is a reasonable dose and the way that you are taking it the auto-inhaler is a good"* (L52-53). The patient brings this utterance to an end by talking over the doctor topic change by asking *"am I okay to get a repeat prescription for that because I will be running out shortly"* (L54-55). Analysis of this extract has highlighted a complex sequence of interaction. In part, the complexity was the result of two factors. First, the medical talk involving the different names of drugs and devices was complicated and difficult to follow[21]. Second, refusing was found to be a difficult interactional matter. The analysis identified that this refusal contains a number of features or components that are characteristic of everyday refusals (Potter, 2000 p60). First, although the request was very early on a direct response was postponed until much later. Second, the word 'now', although acting as a marker to indicate a refusal was on the cards, only served to increase the delay before the refusal was made. Third, when the doctor did raise the refusal the patient was not given a categorical 'no'; instead the refusal could only be inferred. Fourth, the refusal was

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[21]To begin with, analysis of this extract was especially onerous. It was necessary for me to reach a greater level of familiarity about the different treatments for asthma than I already possessed. So, to ensure I was not simply making assumptions relating to the different inhalers discussed or relying on 'intuition' I asked 3 GPs and a nurse specialising in asthma for some guidance relating to the management of this condition in general practice. They were also asked for their thoughts on what was happening in this extract. The practitioners interpreted the transcript in different ways. Although each had described the extract as complex and 'messy' there was a major difference of opinion with regard to their 'medical' perspectives. The nurse and one GP said the extract was difficult to follow and understand as the doctor was not listening to the patient. The doctor should have explored further the patient's concern and it was suggested that had this happened then there would have been no misunderstanding and the interaction would not have been so complicated. The second GP stated that it was possible to identify what the doctor was trying to do and suggested that in general the doctor was simply asking for information through which a misunderstanding could be resolved. The third GP suggested that doctor was irritated with the list of items the patient brought and the patient was manipulating the doctor and finally, the doctor was having a bad day.

followed up with justificatory accounting. These four components work to avoid the peccadilloes that outright refusal may incur (e.g. a more direct refusal in the form of 'no' may be seen to breach the everyday rules of good manners). What can be concluded from the analysis of this extract is that the business of refusing is interactionally much more complex than the granting of a request. Furthermore, this refusal took much longer to accomplish than the successful examples seen earlier. Analyses of further examples where patients' requests are refused may illuminate whether or not it is easier for the doctor to say 'yes'. If this should turn out to be the case then it may have practical implications in day-to-day management in general practice, not least in terms of the time spent in consultations. In the present dataset there were no further examples of request refusals. However, the final extract is taken from a consultation where the patient has requested anti-depressant treatment. The request is eventually granted but in contrast to the first three examples in this chapter, the successful accomplishment takes a considerable length of time.

6.11 Accounting for accountability

Unlike earlier analyses, where small sections of the consultations were extracted, the majority of this consultation will be analysed in three parts. Whilst this is a long consultation, it is not length *per se* that means that it has be to 'chunked' into three sections but rather that the consultation lends itself to an analysis based on the rhetorical structure of request. The formulation of this request is built up over a series of turns, followed by the doctor's evaluation/formulation which is based on interaction with the patient but which is still in mainly non-clinical terms, and finally the 'firming up' of this

in terms of re-formulating it as a clinical matter thus providing a warrant for granting the request.

6.12 Extract 8 D1JPF (1) 'Feeling low and requesting anti-depressants'

The first section attends to the talk between L1-36. This is taken from the beginning of the consultation and it is within this section that the patient constructs a request for anti-depressant treatment.

1. Dr: Have a seat (.) How are you today
2. Pt: Not too bad
3. Dr: Good
4. Pt: Not too bad
5. Dr: Wh:at can I do: for you to:day (.) is this your fi:rst visit
6. ba:ck since we met about a month ago
7. Pt: Yeah yeah apart from coming in (with)
8. Dr: (Yeah) with your wee one
9. Pt: Em well Claire Jones
10. Dr: Yip
11. Pt: She's my Health Visitor and we've discussed anti-
12. depressants a couple times (.) with her and (.5)yourself and she
13. just thought it might be a good idea to eh maybe come in and
14. speak about that today and see if it is okay to maybe start them (.)
15. I feel (.) I feel like I would (.5) benefit (from)
16. Dr: (right)
17. Pt: (maybe) being on them
18. Dr: Right
19. Pt: Maybe pick me up a little bit
20. Dr: Do you fee:l a:ny better than you did a month ago
21. Pt: I feel slightly better to be honest
22. Dr: Yeah
23. Pt: The thing is (.) I tell you some days I feel fine and other days
24. you know I just go back to feeling the same way again
25. Dr: Right Right
26. Pt: I think it just depends whether I have had a good night's sleep
27. or not
28. Dr: Right
29. Pt: I think we've put a lot of it down to sleep deprivation and
30. Dr: Right
31. Pt: I have been referred to the sleep clinic
32. Dr: yeah you mentioned that
33. Pt: Yeah so I have got an appointment with um (.) a lady there next

34. week and we will see if we (get)
35. Dr: (Yeah)
36. Pt: (anywhere) with that
37. Is sleep a pro:blem with feeds during the night

The opening of this consultation is seen to contrast with the more typical openers found in the dataset such as 'what can I do for you'. The doctor does not ask this question on this occasion but invites the patient to say how she is (L1). This serves to set up the consultation on a more casual and social footing, i.e. this utterance may be more typical of how one might greet a friend or acquaintance. In response to the doctor's opener the patient informs the doctor that she is 'not too bad'. After the doctor responds with 'good' the patient repeats her previous utterance. The 'not too bad' (L2, L4) again, may be seen as typical of answers given in response when asked the 'how are you?' question. In mundane conversation it is generally not expected that a person at this point will answer in any detailed way.

The point to note here is the patient has formulated her answer in a similar casual and social way. What is incongruous here is that the patient is at the doctor's and is about to make a request for anti-depressant treatment. It appears here though that the consultation is not likely to progress expediently if the participants continue on this footing. The doctor is seen to return to business by 'starting again'. It may also be the case however, that the patient's 'not too bad' response may function to orient the participants to a previous visit when the patient had actually been 'not too good'.

The doctor performs the two-question sequence where patient is seen to respond ultimately to both questions (L5-6) but as has been found to be the norm, the second question is answered first. It takes the patient some time to answer the first question and

make her request known. The request is not expressed until after the patient has constructed a justificatory account that provides warranting for this (L9-19). The first thing the account does is to locate the request as having been initiated by an external agent, the health visitor (HV) *"She's my health visitor and we've discussed anti-depressants a couple of times ... with her...thought it might be a good idea to eh maybe come in and speak about that today and see if it is okay to may be start them"* (L11-14). The patient does not explicitly state that the HV had actually told her to ask for anti-depressants. The indirectness of this formulation serves to keep the matter open; especially as the patient is saying that she was advised to 'speak about it'. This implies there is room for discussion with the doctor.

The request is further strengthened with the category entitlement surrounding health visitors and effectively works as an inferential resource. First, it provides a degree of consensus and corroboration for the request, i.e. it is championed by a health visitor. Second, the situated use of this MCD is positioned alongside the intimation that the doctor has previously discussed anti-depressants with the patient. Together, these components are packaged in such a way as to provide legitimacy for the patient's request. Additionally, the construction of the request makes it difficult to undermine or reject as any disagreement by the doctor could be viewed as both negating the previous diagnosis and also undermining a colleague's opinion. It is also possible that from the inferential resources available within the membership category HV (i.e. the HV visits the patient in her own home and is likely to have a better idea about the patient's daily life and activities as the mother of a new baby) there is available the inference that the HV may have more expertise/ability than the doctor to make diagnosis.

The patient is seen to continue to provide further justification for her request. The feature to note is the way in which she describes what the anti-depressant treatment will do for her *"I feel I feel like I would benefit from maybe being on them. Maybe pick me up a little bit"* (L15, 17, 19). This description performs a variety of actions. First, the emotive 'I feel' provides subjectivity that is difficult to dispute. Here the patient can be seen to attend to a dilemma of stake and fact construction. The appeal to the emotional is rhetorically persuasive as claims to 'feelings' cannot be proved or disproved. Next, the words, 'maybe pick me up a little bit', formulates the patient as an autonomous agent. The division of 'I' from 'Me' is a useful rhetorical device in terms of showing that the person has exercised some degree of self-reflection as to what is 'best' for them. It can also work the other way as an excuse: "I don't know what came over me". In effect this re-specifies Mead's notion of there being 'I' and 'Me' aspects to the self as discursive constructions (1934)[22]. Besides providing the patient with a degree of authority this utterance effectively works to bring the number of agents in support of the request to three (HV, doctor and now the patient herself) and serves to further strengthen the degree of consensus and corroboration.

There is a further feature of interest with the words *'maybe pick me up a little bit'*. Not only does the patient present her expectations as modest, the nature of the condition requiring treatment is also constructed as unexceptional or moderate. The significance of the condition is minimized into something more normal e.g. unhappiness rather than a pathological condition. This formulation may orient to the stigma of having a mental

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[22] G H Mead said in Mind, Self and Society, " the "I" does not appear in the same sense in experience as does the "me."" (p.178). "The self is composed of 'I' and 'me'". "'I' am impulsive, disorganised and animalistic". "'Me' is my vision of myself reflected in the reactions of others. The self is reflexive and views its actions as a spectator of others" (pages 144-178; 192-200).
Source: www.atschool.eduweb.co.uk/ barrycomp/bhs/duffers

health illness and so is set up to avoid any imputation of this. This matter will be returned to later.

As can be seen, the doctor begins to address these implicit issues by asking the patient *"do you feel any better than you did a month ago?"* (L19). The patient reports some improvement *"I feel slightly better to be honest"* (L20). The 'slightly better' is not followed through with detail or examples that could be used to back up this claim. In fact, the opposite is more likely. This statement is expanded and essentially is reformulated *"some days I feel fine and other days you know I just go right back to feeling the same way again ... I think it just depends whether I have had a good night's sleep or not I think we've put a lot of it down to sleep deprivation and I just go back to feeling the same way again"* (L22-25). In this sequence it appears that the patient is orienting to the temporality of the condition. In other words, the patient implies that the condition is something that she needs help to get over in the short term as her baby develops and a 'normal' sleep routine is established. This interpretation is reinforced when the patient places the locus of the problem as sleep deprivation, which has arisen because of her baby's poor sleep pattern (L26-36). After informing the doctor that she has been referred to the sleep clinic and providing details of the appointment the doctor asks *"Is sleep a problem with feeds during the night"*(L36). It would appear that this question implies that the doctor has identified that the patient may not be experiencing a disturbed sleep pattern because of clinical symptoms of depression: rather the baby is keeping her awake. A discussion about the nature of the baby's feeding and sleeping patterns follows but this has been omitted from the extract (full transcript is available in the Appendix).

This first section of the extract has described how a patient's request for anti-depressant treatment is constructed in part to 'normalise' her 'mood disorder'. The patient was seen to set up the request by presenting the condition as temporary and transient. The components within the justificatory account included strategies to prevent potential undermining, e.g. building consensus and corroboration using various agents e.g. a membership categorisation device to strengthen the warranting. The patient has not as yet offered any particularly clear 'symptoms' that would indicate she is suffering from clinical depression. The doctor was seen to orient to these issues at the end of this section.

The way this request has been formulated places the doctor in a potentially delicate situation with something of a dilemma to deal with. For example, it will not simply be a matter of course to prescribe the treatment because a health visitor had suggested it, or it had been offered on a previous occasion, or the patient 'feels' it might help to 'pick her up a little bit'. The warrant for prescribing anti-depressants will need to be framed as a particular kind of issue i.e. a medical/clinical issue.

The next section, from the same consultation, continues from a point after the participants had discussed the baby's sleeping behaviour. Here the patient had essentially attributed her condition to disturbance arising from the baby's night-time feeding pattern. Line numbers begin again at number 1.

6.13 Extract 9 D1JPF (2) 'Formulating doctorability'

1. I think that is mainly why I feel low in mood sometimes

2. Dr: Well that is quite understandable
3. Pt: I am just so exhausted sometimes
4. Dr: Yeah yeah (.) The first time you came in it would seem that
5. there was a bit more to your mood than just the (.) you know (.)
6. you were quite isolated as well
7. Pt: yeah (.) well (.) I mean that's a bit of a problem as well
8. Dr: yeah yeah (.5) Anti-depressants I think eh (.) my feeling after
9. the first interview was anti-depressants will definitely be of benefit
10. to you (.) em (.) but there was the slight reservation you had about
11. the impact on the wee one
12. Pt: Yeah
13. Dr: if you are breast feeding and we talked a bit about risk benefit
14. and how although there is a very small risk of transmission through
15. breast milk it is pretty negligible and most decisions would be
16. based upon you know the need for the anti-depressant. You know
17. you wouldn't put someone on who doesn't need it and if there is a
18. need for an anti-depressant I suggest that the benefit you would
19. derive from that is greater than the miniscule risk that there is em
20. and I think that would still be you know that is the decision that we
21. have to be happy with that you know em I think the manufacturers
22. always are a bit eh sitting on the fence when it comes to pregnancy
23. and lactation because the studies that they have done haven't
24. involved great numbers and it is often animal studies that they base
25. their results on and em so they tend to err on the side of caution (.)
26. rather than you know (.) say it is okay to take tablets (.5) you often
27. find (.) you know looking through the lists of drugs for pregnancy
28. or lactation the manufacturers advice is avoid and then in practice
29. find that the specialists are using these drugs quite commonly
30. without any problems (.5) my experience over a few years in
31. General Practice has been women who get anti-depressants still
32. continue to breast feed without a problem
33. Pt: Right yeah
34. Dr: and that they have no detrimental effects on the wee one so
35. I would say we should give it a go
36. Pt: Yeah (.) I think:
37. Dr: that would be my:
38. Pt: Yeah it is reassuring yeah to know that (.5) the only other
39. thing was the weight gain as well (.) I am really struggling to
40. lose weight and I don't want anything that is gonna you know (.)
41. that's going to make me put on any more weight because I
42. couldn't handle that

After a review of the baby's night time sleeping and feeding patterns the extract begins from the point where the patient is heard to sum up by attributing the cause of the condition to sleep deprivation *"I think that is mainly why I feel low in mood sometimes"*

(L1). The point to note is that the patient does not describe the condition as 'depression'. Using the term 'low mood' downgrades an imputation of abnormality or pathology. This formulation works to minimise the seriousness of the condition and construct it as something minor.

This is seen to set up a problem. It will be difficult for the doctor to justify prescribing anti-depressants for someone only because their sleep has been disturbed owing to a nursing baby. The doctor's response at this point is seen to contrast with the more immediate grantings (extracts 1-3) or the beginning of a refusal (extract 7). The patient is told *"Yeah yeah the first time you came in it would seem that there was a bit more to your mood than just the you know you were quite isolated as well sometimes"* (L4-6). On this occasion, the doctor does not respond with 'right' or 'okay' (earlier seen as indicative of a granting), nor does the response suggest the beginning of a refusal as the word 'now' had been seen to do. With this response the doctor orients to the problem and the talk performs three actions. First it serves to provide (cursory) agreement with the patient's previous utterance 'yeah, yeah'. As the patient's prior claim had been constructed to prevent undermining with the 'I feel' device, to disagree directly would set up a problem for the doctor. Second the doctor follows through with '*you were quite isolated as well'* and this utterance has the action of drawing upon a social factor to help account for the patient's condition. Introducing the social at this point implies that the other reason given for the low mood (sleep deprivation) by itself is not satisfactory for the doctor. Third, the doctor has supplied a second reason to account for the condition (a case of two heads being better than one). Together these actions can be seen to orient to a problem within the justifications underpinning the patient's request. As a result the granting of the request is not yet forthcoming.

The patient responds with *"yeah well, I mean that is a bit of a problem as well"* (L7). This utterance does not provide complete agreement however. The 'yeah well' and 'a bit of a problem' works to imply that 'isolation' is not given the same status as the disturbed sleep as a factor in causing the low mood. The utterance is formulated to deal with issue(s) of personal stake and is formulated as a disagreement but only in an implicit and indirect way.

The beginning of the next sequence the doctor returns to the patient's request and does some remembering *"yeah yeah, Anti-depressants I think eh, my feeling after the first interview was anti-depressants will definitely be of benefit to you, em, but there was the slight reservation you had about the impact on the wee one"* (L8-11). This sequence begins to construct the 'case for or against' prescribing anti-depressants now. The doctor continues with a long uninterrupted sequence of talk. The detail provided constructs a justificatory account in the form of risk assessment (L13-32).

What is seen as something of a puzzle is the amount of detailed information made available to the patient. As discussed previously, granting requests or accepting invitations are accomplished quickly and directly (Potter 1996). Upon examination this lengthy sequence is seen to be variable and contradictory. First, the doctor is seen to refer back to the decision made on a previous visit and reminds the patient that she had concerns about taking this medication when breast feeding (L8-11). This talk reminds the patient that the doctor had been of the opinion anti-depressants would be good for the patient but it was the patient who had reservations. The implication is that the medication would have been prescribed then, but for the patient's concerns. It also

provides some warranty should the doctor decide to grant the request now. Warranty is supplemented with the utterance *"although there is a very small risk of transmission through breast milk it is pretty negligible"* (L14-15). This works to construct risk to the baby as minor and of little significance. Next the patient is told *"most decisions would be based upon you know the need for the anti-depressant you know you wouldn't put someone on who doesn't need it"*. This utterance orients to a number of issues. It informs the patient that anti-depressants will not be prescribed unnecessarily and also indicates that a refusal may still be on the cards; it allows the doctor to 'sit on the fence' and/or provides an opportunity to pass the decision over to the patient. Overall this talk constructs an account of accountability by raising 'legitimacy' as a concern for participants. After drawing the patient's attention to the doctorability issue the doctor performs further risk assessment *"and if there is a need for an anti-depressant I suggest that the benefit you would derive from that is greater than the miniscule risk that there is em and I think that would still be you know that is the decision that we have to be happy with that you know"* (L17-24). This talk makes known that there is indeed a problem over whether or not anti-depressant treatment is necessary. In spite of this, the patient is then provided with information that can be seen to undermine the details provided by the manufacturers about the risks relating to breast-feeding (L21-31). First, the formulation works to imply that the drug manufacturers are over cautious. Second, the caution is undermined owing to a lack of evidence as a result of 'small numbers' and 'animal testing'. Third, the doctor reports that 'specialists' are using these drugs commonly without problems. Finally, the doctor constructs a claim that will be difficult to undermine with the comment *"in my experience... women who get anti-depressants still continue to breast-feed without a problems"* (L30-32). Together these activities work to construct a very strong claim that the risks involved in taking anti-depressants

is minimal. The patient's first clear response to this account is *'Right, yeah'* (L33). The 'right' alongside the 'yeah' is heard as an agreement and the doctor is seen to wrap things up with a final warrant before indirectly agreeing to the request *"and that they have no detrimental effects on the wee one so I would say we should give it a go"*. The formulation of the 'so I would say' agreement is interesting as it gives an impression that it has been the doctor's decision to grant the request and the 'we should give it a go' provides the permission for both participants to 'act' on this and thus provides the first clear indication that the anti-depressants will be prescribed. After this the patient's response introduces a further request that is formulated as a new but related matter i.e. potential weight gain as a side effect of the proposed treatment. The patient has not agreed to the decision unconditionally.

The second section of Extract 13 has described and detailed the ways in which the doctor is seen to construct an account of accountability for granting the request for anti-depressant treatment. The patient had not provided the doctor with the information that would clearly substantiate a decision to prescribe anti-depressant medication. Instead, the baby's (disturbed) sleep pattern was set up to be responsible for the patient's low mood. As a result, the low mood was not formulated as a medical condition and this amounted to a 'doctorability' (Heritage, 2001) matter, which placed the doctor with a delicate situation. The doctor attended to this legitimacy issue by carrying out some extensive and detailed risk assessment. This accounting was underpinned with a number of discursive strategies that were deployed to minimise the risk of transmission of the drugs through breast milk. For example, by questioning the validity of manufacturers warnings the doctor was able to undermine the risks involved as being negligible or insignificant. The doctor's talk was also strengthened with the deployment of external

corroboration i.e. 'specialists' and personal experience. The analysis has also identified a doctorability issue with the patient's request and her justification for the treatment. It is likely that this problem relates to an absence of evidence for the requested treatment as the patient has not presented with or expressed any substantive clinical signs. However, the granting of the request has been done.

The third extract charts a return to a clinical evaluation of the patient's symptoms as a warrant for the decision to grant the request. A significant amount of talk has been omitted where the participants discuss the patient's weight concern and contraception (full transcript in the Appendix). The sequence begins with the doctor bringing an end to this by returning to what the doctor sees as the primary matter, reviewing the patient's clinical symptoms of depression.

6.14 Extract 10 D1JPF(3) 'Formulating the condition as medical'

1. Dr: Are you weepy at all (.)going back to your sort
2. of depressive symptoms (.) You're still a bit la:bile (.) e:motional yea:h
3. okay (.) have you talked eh (.) Claire did a scale on what we call a
4. post natal depression scale and you scored quite highly and so it does
5. suggest that you are going to benefit from:
6. Pt: Yeah I do think (.) Yeah I think I would benefit yeah I am quite
7. keen to start them now to be honest
8. Dr: Okay let's talk about your concern about your weight gain

(section of talk omitted relating to weight concern)

9. Pt: I am (.) I think it is because I am bored sometimes in the house
10. Dr: Right and that can be a symptom of depression can't it (.) you know
11. (.) either loss of appetite or eating for em (.) comfort eating and then you
12. feel bad about yourself afterwards
13. Pt: cos I can't really get motivated to do much in the house and things
14. like say I have not had much sleep that night I just sort of sit there
15. Dr: Yeah it is just sort of a survival type thing
16. Pt: yeah
17. Dr: So I think the feeding issue and getting sleep is important too
18. because you are not losing sleep because of an illness I think you
19. are losing sleep eh it is enforced (.) it is sort of sleep deprivation
20. Pt: Yeah (.5) Cos I did like my sleep before so I really take bad with
21. it (quietly spoken)
22. Dr: What about during the daytime (.) does he feed as often as that

23. during the day

(11 lines of talk omitted where patient describes the babies daytime feeding activities)

24. Dr: Right so its a habit that he has developed which er
25. Pt: I tried not to get into that habit but it has been really
26. difficult to avoid it
27. Dr: You have obviously talked through this with the Health
28. Visitors. I'll (.) I think (.) you know (.) that is something you're
29. needing to discuss a bit more (.) the sleep pattern (.5) What I
30. suggest we do is put you on a pill (.5)one a day and it is called
31. Paroxitine (.) Erm (.) it will (.) the first two weeks when it is
32. bedding in you will not notice a significant benefit but you
33. might notice the side-effects significantly
34. Pt: Which a::re

The talk in Lines 1-5 constructs a justificatory account that provides mitigation to uphold and strengthen the earlier decision 'to give it a go'. The words, *"going back to your sort of depressive symptoms"* (L1-2) marks an orientation to the medical. Here the doctor is seen to use a non-pathological descriptor of the condition. The use of 'sort of' works to minimise the condition and, in effect, aligns with the way the patient had normalised the condition earlier. This sequence of talk also includes the deployment of a three-question sequence, *'are you weepy at all'*, *'you're still a bit labile, emotional yeah'*, and *'have you talked er'*. Within this sequence the doctor is seen to answer two of the three questions him/herself. There is little space available for the patient to respond to any of them. In fact, the patient is ultimately seen to respond to the doctor's summation rather than to any question (i.e. the patient had scored quite highly on a post-natal depression scale then she will benefit from the treatment).

A further feature to note is the different kinds of descriptive terms used by the doctor. The term 'weepy' and 'emotional' are seen to contrast with the medical term 'labile'. This performs two actions. First, it constructs a picture of normal versus pathological. This orients to the concern of the patient i.e. holds on to the patient's construction of normality (i.e. low mood as opposed to depression) without undermining this.

However, this particular picture of meaning or understanding is contradicted when the term 'labile' is included. From a medical perspective 'labile' or 'emotional lability' is used to describe inappropriate laughter or crying and is usually used to describe symptoms indicative of a serious condition and therefore, is an unusual term to use when talking about a 'low mood' (and especially with a patient). Here, it is seen to counter any picture of ordinariness by formulating a clinical case for anti-depressants.

There is a further strategy deployed within this account that serves to add further strength to the medical warranting, a post-natal depression scale. Here, the reference to the post-natal depression scale provides an externalising device provides an example of 'empiricist accounting' (e.g. Gilbert and Mulkay, 1984; Potter 2000). This form of accounting works to make available inferential claims for objectivity and facticity. In other words, it functions to transfer agency from the doctor and locate it with the post-natal depression scale and so formulates matters in such a way as to suggest that the doctor's personal view (on whether or not the patient is clinically depressed) will not be seen as an influencing factor in the decision.

The doctor continues with further warranting. The patient's non-clinical attribution for weight gain that she is 'bored sometimes' is taken up as another opportunity to medicalise'. The doctor responds with *"and that can be a symptom of depression can't it, you know, either loss of appetite or eating for em comfort eating and then you feel bad about yourself afterwards"* (L10-12). This account is constructed to cover all bases. First, it re-affirms the condition as clinical, e.g. a symptom of depression. Next it provides the inference that any deviation from normal eating i.e. too much or too little is pathological. Finally, this is strengthened with the words 'feeling bad afterwards'. Here,

an allusion to another symptom of clinical depression is invoked, 'feelings of unworthiness'. With the additional expressions of 'can't it' and 'you know' are seen to invite the patient to agree with the implicit warranty to claim that the patient's condition is pathological. The patient is seen to align with the doctor's account by providing further information that is not formulated to undermine or challenge the picture just painted.

The doctor returns to the sleeping and feeding issue. What appears unusual here is that the following talk could be seen as re-introducing a case for not prescribing anti-depressants, *"So I think the feeding issue and getting sleep is important too because you are not losing sleep because of an illness I think you are losing sleep eh, it is enforced, it is sort of sleep deprivation"* (L17-19). The doctor's talk has done what the patient's talk had done, i.e. not attributed the cause of the patient's sleep problems to an 'illness' but rather the result of external factors 'enforcing' it. After further extensive discussion detailing the impact of the baby's and the patient's 'habits' (L24-25) and the health visitor's involvement (L26 -28) the doctor proceeds to inform the patient that she will be 'put on' Paroxitine[23] (L28-30). There follows a topic shift when the patient is told that she might notice some unwanted side-effects. This shift prevents the opportunity to check out the patient's agreement with this course of action. Nor is the patient asked directly. In effect the decision has been made and all that remains is to provide the patient with the requested information relating to the treatment side-effects.

The third extract, taken from the same consultation, has illuminated and described some of the discursive activities involved in formulating the patient's reported 'low mood' as

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[23] Paroxitine is the generic name for Seroxat. This anti-depressant is classified as an SSRI (selective serotonin re-uptake inhibitor).

a clinical condition and in order to provide a warrant for anti-depressant treatment. The main analytic concern related to a problem over the 'medical' evidence presented by the patient to justify the request for anti-depressant therapy. Analysis has identified contradictory discourses within the accounting practices used by the participants to mitigate and grant the patient's request, e.g. normal versus pathological. The doctor has attempted to establish whether or not the patient is 'truly' suffering from a medical condition or if she is experiencing what could be viewed as a non-pathological reaction to her current circumstances and environment. The patient's account of her condition for the most part is formulated to minimise the concept/construct of a psychiatric disorder. The patient uses language that is seen to normalise her condition. The doctor's account of it was more varied and at times it was seen to pathologise and normalise the condition. As a result, granting of the request was made more difficult because of this variability. What is clear is that whilst the doctor worked hard to package the condition as clinical the warranting work done by the doctor was at times contradicted and undermined by the doctor him/herself. The key analytic point here is that 'decisions' are emergent and evolved properties of the interaction that take place and not as a result of the medical business as such.

6.15 Discussion

Initially, as there were so many examples where patients took the initiative and made direct requests about treatment decisions affecting their healthcare, on the surface at least, SDM did appear to be in force. After discourse analysis however, this particular approach to treatment decision-making can only be upheld if particular events or features within the interaction are ignored. In other words, to take a representational or

cognitive view of language use, it could be supposed that the patients who made direct requests for particular treatments or courses of action were 'simply' more assertive or knowledgeable about their own health and health care. Examining the discursive activities provides a different view of reality however. The nature of SDM is complex and sharing decisions does not emerge simply from following a list of prescribed activities, as presented in the theoretical frameworks.

The extracts in this chapter identified a variety of discursive strategies that were used to help construct warranty for patients' requests. In extract 1 the patient had constructed the concern as a major-minor problem. This formulation was difficult to undermine and so made it difficult for the doctor to even suggest a different treatment option from those framed by the patient. In extract 2, the patient's request introduced a problem i.e. no visible evidence that would endorse the request for specialist investigation. Here a number of strategies were used to legitimise and provide warranty for the request. These included justificatory accounting, laughter and active voicing. In extract 3 the strategy of active voicing was used again to introduce a rather persuasive external agent, the voice of others to aid the legitimacy of the request. An additional device of 'particularisation' was also deployed here to further strengthen the claim. It was noted too that patients also orientate to an implicit issue of bringing more than one concern to the doctor's attention. Subtle differences were seen in ways this matter is addressed. Extract 4 provided an interesting example where the patient and the doctor were seen to deal with an implicit request for 'permission' to stay off work. On this occasion the patient formulated matters in such a way to try and pass the responsibility over to the doctor. However, the doctor did not take this up and the decision-making was resisted and instead passed back to the patient. Extract 5 provided an example where the 'medical talk' was seen to limit the patient's opportunity to participate fully. The

medical review carried out was very much doctor-centred and as a result left little space for patient involvement. It was also suggested however, that the formulation of the patient's initial request in the opening phase did not work to construct a picture of an assertive patient and so may have set up the space for the doctor to take control. Extract 6 identified variation in how the opening phase can be seen to function in different ways. On this occasion the doctor had asked the patient 'what can I do for you'. The 'I' deployment was seen to open up a space for the patient to be involved. In contrast to extract 5, the patient in extract 6 was directly invited to participate and had negotiated her conversational space early on and thus, was actively involved in the decision-making. Extract 7 presented an example where the patient's request is refused. The formulation of the refusal was seen as complex and it was noted that refusals take significantly longer to accomplish. In addition the formulation of the refusal did not indicate a shared decision had been accomplished. In the final extract (8) the doctor was seen to agree to a request for anti-depressant treatment. The notable features of this extract included an illumination of the complexities surrounding the construction of appropriate warranty to grant the request. In addition, there was variability in the ways the condition was constructed as both normal and pathological. Both participants were seen to orient to this and formulated accounts and claims accordingly. As a result, this variability may have served to postpone the granting. It is also possible that as the patient had only 'wondered' when bringing the request this formulation may have made it easier to refuse. In the examples of successful requesting the patients were much more direct and none had 'wondered' over requests.

It has been suggested that patients are not in the habit of making direct requests for treatments or resources when they visit their doctor. Rather than formulating their

requests directly patients instead only 'suggest' (ten Have, 2001) and tend to "use covert strategies in taking the initiative" (ten Have 1991) or "hold off their 'lay diagnosis' until the physician has spoken" (ten Have 1996). These patient behaviours have often been regarded as markers of an asymmetrical relationship with the doctor. Some of the concerns that prevent patients from taking the initiative may include the fear of being seen to be doing the doctor's job, or asking for expensive treatments etc. On the other hand Robinson (2001) suggests that in primary care for non-diagnostic services requests for prescriptions or medical lines are viewed as a common course of action for patients. It is clear there are differences of opinion relating to patients' requesting behaviours. However, this discrepancy may be of little consequence. Reasons may have more to do with differences between the services or treatments actually requested or the patients level of involvement. There does not appear to be evidence available reporting studies that have compared requests for different medications, resources or services. If there is to be more partnership in the form of active role taking in the consultation it would appear prudent for patients to take the initiative more and be direct about what they are actually seeking from their doctor. However, this would present a problem that would set up an ideological dilemma over expert versus lay knowledge as a basis for treatment decision-making. There may be particular practical consequences as a result (e.g. longer consultations).

CHAPTER SEVEN

The Discursive Construction of Risk and Agency

7.1 Introduction

As has been stated, the principles of shared decision-making advocate that patients should be encouraged and given the opportunity to be involved in their own healthcare decisions (e.g. Coulter *et al*, 1999). This involvement is expected to position patients as agents for their own health and health care. In order to participate as active agents, patients will need to be informed by sound and 'impartial evidence' [24] on which to base their decisions. This claim lends itself to the call for health care practice to be evidence-based. Evidence-based practice (EBM) has been described as an initiative committed to reshaping biomedical reason and practice that sets out to establish scientific research as a fundamental ground of medical decision-making (Mykhalovskiy and Weirb, 2003). These authors describe EBM as comprising two components or aspects: clinical epidemiology and clinical reason. The interest at this point is with the former. For example, in terms of risk construction epidemiology is concerned with clinical trials and population health. However, there are a number of problems with the execution of an evidence-based approach to healthcare. For example, there are difficulties in establishing exactly what constitutes evidence and also conflict over which body of evidence should be used to support particular treatment options. In terms of the public

[24] From a social constructivist perspective, the term 'impartial evidence' would be seen as something of an oxymoron.

versus individual level, according to Ashcroft et al (2001), there may be an implicit political economic agenda determining targets or outcomes.

7.2 The variability involved in the construction of risk and evidence

This chapter explores the discursive construction of agency, risk and evidence. The objective is to examine the formulation of these discourses as participants concerns taking the view that these discourses are rhetorically constructed, are active and require warrants that can be located in the past, present or future. The aims are to identify and describe the construction of treatment choices that use these discourses and to examine how 'choosing' is a matter of joint production. Like agency, risk and evidence 'choice' does not just exist, it too is rhetorically constructed. This chapter presents the analyses from 7 extracts. These have been taken from consultations involving discussions over HRT, Hypertension and Viral Illness.

In Extract 1 the patient is seeing her doctor for a review of hormone replacement treatment (HRT). The extract begins at the point where, as part of the HRT review, the doctor is in the middle of checking the patient's blood pressure (BP). An electric measuring device is being used to do this.

7.3 Extract1 D2SLF 'Problem over electronic readings'

1. Dr: Okay. Right if you just rest your hand it (.) works on
2. pressure this so we need to just need to have a nice:
3. Pt: No I'm quite happy on it like (coughing)
4. Dr: Okay.

(beeping noise for 1 minute)

5. Dr: Oh great after all that it hasn't recorded (.) bear
6. with me a moment (.) I'll let your arm recover and then
7. I'll just give it one more go
8. Pt: Mhmm (laughing) Gadgets e:h
(Beeping noise)
9. Dr: I was just che: I couldn't remember for some reason
10. what the Climaval was so I was just checking
11. Pt: Oh
12. Dr: So it is just one of the oestrogen only ones (.5) you
13. have ha:d your hyster:ectomy
14. Pt: Yeah yeah
15. Dr: Yeah (.) okay (.5) thats half the drawbacks of HRT out
16. of the way isn't it Ha Ha Ha
17. Pt: (laughing) tr:ue
18. Dr: Just pop that down there
19. Pt: The only other thing is I've had a right dry mouth and
20. I am always thirsty and am unable to quench my thirst and
21. this past week I was on a course of tablets from the dentist
(interrupted by noise and the machine starting up again)
22. and my tongue is really coated and furry
(Buzzing noise of machine)
23. Dr: Okay so are you passing quite a lot of urine as well
24. Pt: I could do at times yeah (.5) I am drinking
25. through the night as well
26 Dr: Okay okay can I get just to you keep nice and
27. still for (.) any movement disturbs that thing (1.) we should
28. probably think of just checking at some point for diabetes if
29. you are doing that, if you are being thirsty and passing urine a
30. lot (1.) is there any his:tory in the family of i:t (beeping)
31. Pt: No no (.5) just with the constant thirst and my mouth dry and:
(24 second gap in talk followed by beeping noise)
32. Dr: All right your blood pressure is up a little bit (.5) there (.5) so
33. I'll just wait to repeat it again (.5) I'll just get you a bottle and you
34. can just give us a sample at your convenience just to test and make sure that
35. (7 sec pause) for some reason you are not slipping down that line (.5) it
36. would be sensible just as a precaution (.) anythi:ng e:lse (.) do you
37. ha:ve mu:ch salt in your di:et
38. Pt: No I'm not a salty person actually (3.) I mean if it is seasoned when
39. it's cooked that's me basically
(8 second pause while the doctor is writing on specimen container)
40. Dr: Okay I'll check that one more time.
(Buzzing and beeping noises 30 second pause)
41. Dr: your blood pressure in the past there's been the
42. odd high reading but em (.5.)
(beeping)
43. Pt: yeah I think the last time was because my father had just died
(Beeping)
44. Dr: Right (1.) the last time you came to see me it was fine (.5)
45. I wasn't worrying about that.
(Beeping)
46. Pt: Well I have got a problem with my daughter just now so that
47. would be:
(Beeping)
48. Dr: Right (3.) Okay (1.) I'm not going to make any decisions on

49. that (.) on what your blood pressure does today and you stay on the
50. HRT that is not a problem (.) but we may be should monitor it.
51. Pt: Yeah
52. Dr: Yeah
53. Dr: What's going on with your dau:ghter (.) is that relevant or:
(text omitted)
69. Pt: But we'll get there (.1) So that's what that could be because I do get:
70. Dr: No problem (.) in that case why not come back in a couple of weeks
71. with a urine sample just to one of the practice nurses
72. Pt: right
73. Dr: And just let them get one of them to check your urine and your
74. blood pressure
75. Pt: Right
76. Dr: To make sure that it is coming down
77. Pt: Right okay (.) it's not high though i:s i:t
78. Dr: Well n:o it is not (.) it's at a level where we would normally
79. recommend treatment though (.) if it stayed there
80. Pt: Yeah yeah
81. Dr: But as you say so we are just checking that this is just a one
82. off rather than you know Yea::h (.5) does that make se:nse (.5) okay
83. so come back in a couple of weeks to see one of the practice nurses
84. and em there's another 6 months of the HRT in the meantime.
85. Pt: Right that's fine okay thanks
86. Dr: Bye
87. Pt: Bye

The participants are simultaneously attending to two matters: the blood pressure (BP) recording and an earlier review of the current (HRT) medication. The extract begins with the doctor instructing the patient to rest her arm as the device works under pressure (L1-8). The patient reports that she is quite happy on 'it' and is seen to be orienting to the 'Climival'. Both participants are silent while they wait one minute for the machine to provide a measurement before the doctor breaks the silence with "*Oh great after all that it hasn't recorded*" (L5). Although this utterance presents a statement of fact the 'oh great after all that' formulates a complaint. Blame is implicated with 'it' but the referent of 'it' is ambiguous, and it is not clear if 'it' is the machine or if 'it' is referring to the fact that the blood pressure has not recorded. It appears that the patient orients to the complaint and the implicit attribution of blame. The laughter[25] alongside the

[25] Laughter as a discursive resource has been discussed in Chapter 5, extract 2

comment *"Gadgets eh"* indicates that the patient treats the matter as sensitive and the laughter orients to this (L8). The patient's comment is formulated to counter a potential criticism that she may have been seen as responsible for the unsuccessful attempt to record the BP (her coughing and/or talking may have caused movement that interfered with the recording). This counter did not appear to be successful however, as the doctor did not return the laughter or respond directly to this comment but was seen to change the topic and return to the HRT issue (L9-10). Of course it is possible that the doctor had not heard the patient's comment at all as his/her attention may have been directed towards the BP machine or checking notes. The amount of beeping makes it likely that the machine will have had an impact on this part of the interaction and, thus can be seen to have acted as a third agent within the interaction. In other words, the presence of the device can be seen to have had a determining power or force over the actual and potential interaction.

The next point of interest involves the doctor's talk between L12-16, *"so its just one of the oestrogen only ones, you have had your hysterectomy"* and *"yeah okay that's half the drawbacks of HRT out of the way isn't it, ha ha ha"*. There are a number of notable features within this sequence. First, it works to construct a review. In addition, the review formulates a warrant for the actual preparation 'Climival'. The words 'so its just ... ' constructs an implicit boundary and works to minimise the risks of this particular preparation in an indirect way. The reason that this is the case is provided in the rest of the utterance 'one of the oestrogen only ones'. This constructs an implicit comparison with implicit 'other ones' (and makes available an inference that there will be less to worry about with this treatment). This utterance is also constructed as if a matter of fact and is a statement that works to close off any discussion over medical

consequences of the particular treatment. A further feature of note is that the term 'drawbacks' is plural so the patient is left to infer that there is not just one 'drawback' but potentially several.

The next utterance '*you have had your hysterectomy*' also provides a statement of fact. As the review constructs facts and 'facts' by default possess a claim for objectivity, it is difficult to undermine so no space is opened up for the patient to discuss matters In addition, this allows the doctor to keep hold of the discursive space and trajectory. The final utterance of the review *"yeah okay that's half the drawbacks of HRT out of the way isn't it, ha ha ha"* is ambiguous. It is not clear whether the patient will infer that the 'drawbacks' are out of the way because she had a hysterectomy or because she is taking 'climival' an oestrogen only preparation. The point being made here is that the formulation of the utterance leaves this matter open for the patient to decide.

A further point of interest relates to the term 'drawbacks'. This term is less precise in medical terms than the more commonly used 'side-effects'. Where the term side-effects can import a direct link to the medication and medical consequences, the word 'drawbacks' work to draw attention away from these. The laughter that follows may also help to play down the matter of risk as a lesser concern and works to invite agreement with the implicit claims of minimal risk. The patient responds to the comment by returning the laughter and agreeing to what was said with '*true*' (L17). This shared laughter can be seen to form an impression of togetherness and partnership.

The patient is seen to introduce a concern relating to having a dry mouth and an unquenchable thirst (L19-22). The extract indicates that she is interrupted by the noise

of the machine when reporting her symptoms to the doctor. Whilst attending to the BP recording machine the doctor asks a question relating to the patients concern *"okay, so are you passing quite a lot of urine as well"* (L23). It becomes apparent that the machine has again failed to deliver a measurement. Amid the diagnostic work the doctor next asks the patient to *"keep nice and still as any movements disturbs that thing"* (L26-27) and informs her that she should be checked out for diabetes (L28). The diagnostic work by the doctor has raised a newsworthy event. However, it is not treated as such.

A particularly notable feature of this sequence relates to the impact the machine has on the conversational flow. This is indicated by the beeping and buzzing noises and also with the doctor's orientation to the machine. During the discussion the machine beeps indicating that it is in the process of recording the BP. This results in an interruption and brings an end to further talk by patient. There follows a 24 second pause while the participants wait for the machine to report back. After the beeping that indicates the machine has finished the doctor attends to the measurement provided by the machine and reports *"all right your blood pressure is up a little bit there so I'll just wait to repeat it again"* (L32-33). The doctor had just raised the second newsworthy event, a concern that the patient might have diabetes. Owing to the interruptions from the machine the newsworthy event is reported in a minimal way. The point is that the machinery and/or the doctor's agenda take precedence rather than opening a space for the patient to comment. This activity is repeated again soon after.

The patient is asked if she takes much salt in her diet (L33-37). This is an important question as salt intake may account for the raised blood pressure. The patient provides a 'no' response (L38-39). This is followed with an 8 second pause while the doctor is

writing on the specimen bottle. When the doctor speaks again the response *"okay I'll check that one more time"* (L40) performs a topic shift and a return to the BP and the patient's answer was not taken up. There are two points of note here. First, it has been recognised that when patients provide information they expect to hear some form of acknowledgement (Jones, 2001). This was not provided. Second, this sequence of talk presented the doctor with an opportunity to inform the patient about 'risk' and 'lifestyle' factors that may be affecting her health. It appears that the issue of risk is not being oriented to as a matter for the patient's concern.

Following a further 30 second pause the doctor makes the comment *"your blood pressure in the past has given the odd high reading but em"* (L41-42). The use of 'but' is used to contradict what has just been claimed (e.g. Tannen, 2003). Here it is used to negate the significance of previous blood pressure readings and indicate that these will not have a bearing on the current situation. The additional action of halted or incomplete responses are also seen to impact on the interaction as a case of action speaking louder than words.

The patient responds by attributing a previous high BP to the death of her father (L43). This formulation provides an implicit claim that stress or emotional upset was responsible for the raised BP in the past. A similar claim is made by the patient to account for the present raised blood pressure and is attributed to problems with her daughter. Further beeping occurs at this point and the patient's utterance is brought to a halt and is left unfinished. The doctor does not take up the unfinished comment but moves on to inform the patient he/she has made a decision *" I'm not going to make any*

decisions on that, on what your blood pressure does today and you stay on the HRT that is not a problem but maybe we should monitor it" (L48-50).

The deployment of the pronoun 'I' constructs the doctor as an independent agent. The words 'I'm not going to...' simultaneously formulate a refusal and a decision (i.e. not make any decisions). It is seen that the agency of the machine, although providing an objectivist basis for diagnosis, is negotiated so as to assert the doctor's agency in the matter of decision-making. It is found that the decision then has been based around the doctor's own expertise. This 'expertise' however, raises a problem.

It is not the first occasion that this patient has been found to have high blood pressure. The words "in the past" and "*there's been the odd high reading*" (L42) confirms this. Note that the term 'high reading' works to avoid the imputation of a medical condition that would have been available if the words 'high blood pressure' had been used at this point. Doctors will not decide on the basis of one high reading that a patient should be prescribed anti-hypertensive medication (and be on it for the rest of their life) unless in exceptional circumstances. It is standard practice to diagnose hypertension if blood pressure measures more than 140/90 mmHg on three consecutive visits over several months [26]. The number of previous instances when the patient was found to have 'high readings' is not stated but 'odd' is used to formulate the high BP as transient. As a result, any significance of today's high blood pressure as a medical concern is minimised. The minimising is further strengthened when the patient is told that her BP

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[26] Blood pressure, similar to all biologic measures, is inherently variable; it is constantly changing and influenced by a large number of environmental, biological, and measurement factors. To partially control for the variability of blood pressure measurements, the diagnosis of hypertension should be based on the average measurement of multiple blood pressure readings taken over two or more clinic visits. The *Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure* (JNC VI) Source http://www.cmeprograms.umn.edu/bestpractice/tomhs/html/other/diagnoshyp.html

will be monitored. This formulation makes available an inference that the BP does not require active treatment and at this point, the 'monitoring' will be enough. Thus, the doctor can be seen to tackling the medical concern and not simply dismissing it out of hand. However, it is notable that the topic here is firmly constructed as one of medical diagnosis on the part of the doctor rather than any concern of the patient.

Moving on, Line 69 shows the patient concludes the discussion over her daughter and brings the conversation back round to the matter of the high BP by once again attributing the cause to her emotional state. The doctor is seen to accept this import and uses it to reaffirm the medical decision made earlier, "*No problem in that case why not come back in a couple weeks time with a urine sample just to one of the practice nurses and just let them get one of them to check your blood pressure*" (L70-74). The patient has effectively been told not to come back to the doctor in person but 'just' see a nurse and 'just' let them check the BP. The use of 'just' can be seen to orient to some other implicit option that may be available (Lee, 1987). Here, 'just' is seen to orient to the potential option that the doctor could make him/her self available to do the monitoring. Additionally, the membership category of nurse in relation to the membership category of doctor makes available an inference that there are different statuses afforded to these two groups. Thus, by telling the patient to see the nurse helps to construct the monitoring as a lesser concern. Following agreement with the doctors' instructions the patient is seen to ask the question "*It's not high though is it?*" (L77).

This question raises a problem. The patient has brought about a re-examination of the issue over her high blood pressure and as a result, works to question the doctor's decision to postpone active treatment. This creates a delicate situation for the doctor.

The response to the patient's question is ambiguous and contradictory. First, the patient is told, *"well no it's not"* (L78) and by implication, then, is a claim that treatment is not required. However, the patient is also told *"it's at a level where we would normally recommend treatment though if it stayed there"* (L78-79). This constructs something of a paradox. This talk serves to claim that the BP is high and should perhaps be treated. However, the claim is left for the patient to choose to take up or not. The patient does not take it up and is seen to align with the 'yeah, yeah' response. This response is oriented to as providing agreement as the doctor brings the issue to an end with the help of three further strategies. First, by way of providing a warrant for the decision, the patient is constructed as an active agent with the words "*but as you say*" (L81). This works to suggest that the patient and her concerns have had a bearing on the decision. Second, the use of 'we' in the next part of the utterance *"so we are just checking that this is a one off"* provides an imputation that the decision was shared. Third, the 'just' is seen to restrict any further discussion by setting out the boundaries for the present consultation and acts to prepare the ending of the consultation. This constructs the decision as being the doctor's with regard to the issue of risk.

Analysis of Extract 1 has oriented to the bearing that 'technology' can have upon the interaction. The blood pressure recording device is seen to get involved in a number of interactional matters. For example, it was seen to interrupt the flow of conversation, bring utterances to a halt and also construct attributions of blame for the machine not delivering a measurement. A negotiation between the machine as agent and the doctor as agent relating to the decision not to prescribe treatment was identified and described. The terms used by the doctor when referring to the side-effects of HRT were also of analytic interest. It was noted that the term 'drawbacks' was seen to minimise and

undermine orientation to the potential risks of HRT as a matter for the patient's concern. A further issue was raised over the minimising of a newsworthy event i.e. the potential diagnosis of diabetes. The use of various strategies and resources such as laughter was seen to invite consensus and to construct an appearance of sharing and patient involvement in the decision-making. On more than one occasion the doctor did not pick up on the patient's constructions as implicit concerns, and essentially, the patient's agenda was relegated to third place with the blood pressure device and the doctor's agenda taking precedence. The use of 'just' was seen as rhetorically persuasive and worked to limit opportunities for the patient to bring her agenda to the fore. Together, the various features and activities constructed a refusal to 'act now' and a warrant for the decision to postpone treatment.

Overall, the rhetorical construction of the HRT review, along with the activities involved in securing a BP measurement, can be seen to be drawing upon a 'risk' repertoire without any single direct mention of the word risk.

Extract 2 presents a second HRT review. Analysis is again concerned with the formulation of risk and agency in the review discussion. The extract is taken from halfway into the consultation, after having dealt with another item. It begins from the beginning phase of the review, recording the patient's blood pressure.

7.4 Extract 2 D3LMF (2nd extract) 'Locating agency and responsibility'

1. Dr: Okay (.) Let's take your blood pressure from the
2. point of view of your Premarin (.5) how old are you now
3. PT: (laughter) Fifty two.
4. Dr: So you've been up to the breast screening
5. PT: Yes

6. Dr: So it's important that you keep going to that with your HRT
7. PT: Aha
8. Dr: Em (.5) Do you keep a check on the breasts
9. PT: Yes (.) No not really (Laughter) no.
10. Dr: It is important (.) I mean the best person to
11. PT: I do: (.) occa:sionally when I think of it I don't think about it.
12. Dr: It's just with you being on the HRT there is a slightly
13. increased risk of breast lumps.
14. PT: I know.
15. Dr: and even some people will say breast cancer as well.
16. PT: I know
17. Dr: The best person that knows your breasts is yourself
18. PT: yourself
19. Dr: And so I mean doctors are quite happy to examine them
20. if you want them to
21. PT: Right (.) Right
22. Dr: But they won't remember what they felt like:
23. PT: Right
24. Dr: last time. (laughter)
25. PT: (laughter) right
26. Dr: So from the point of view of you knowing if there's a
27. difference or not:
28. PT: Right
29. Dr: Then it would make sense that you're the person that
30. keeps a check on them
31. PT: I do do it when I think about it.
32. Dr: Yeah I mean it is important I think (.5) that's the one thing
33. I would say to you is that you should keep an eye on them

At the beginning of the consultation the patient had asked the doctor to check her over as she had returned to taking HRT for two months having had a break from it. The extract begins at the point where the doctor returns to this request. The doctor's first utterance is seen to orient to the risk repertoire with *"Okay. Let's take your blood pressure from the point of view of your Premarin"* (L1-2). This formulation works to raise the matter of risk without directly bringing it up. Whether or not the patient orients to this repertoire is not apparent but is clear the doctor continues to do so after requesting the patient's age with. "*So you've been up to the breast screening*" (L4). The point of interest is with how this statement has been constructed as a question. Here an implicit claim for facticity is formulated with the import that the course of action is obvious and expected and does not actively seek out an agreement. This strategy is

used once again in the doctor's next statement *"so it's important that you keep going to that with your HRT"* (L6). These two closed statements are formulated so as to not present grounds for potential undermining of the implicit claims. This sequence also acts to direct without it being directly commanding. This does not afford space for the patient to seek clarification as to the basis for these directives. In addition, the statements locate agency and responsibility with the patient.

The doctor asks a further and more direct question *"Do you keep a check on the breasts"* (L8). The patient's response orients to a problem. She is seen to reformulate her answer several times *"No, Yes, No, not really, no"*. (L10). Although the doctor's question would not be entirely unexpected it appears that the response aimed to do some damage limitation work. This response indicates the patient is attending to issues of personal stake. The patient is aware that to be seen as non-compliant could undermine a portrayal of a 'good' patient or at worst could be seen as irresponsible and so 'good' patients do what is advised. This face-saving strategy is pursued as the patient interrupts the doctor and reports that she does check, occasionally (L11).

The doctor replies with *"It's just with you being on the HRT there is a slightly increased risk of breast lumps"* (L12). This statement serves to indirectly relocate attention away from the implicit medical consequences of the treatment by constructing them as minimal. This construction also introduces an indirect comparative element i.e. that without taking HRT there is a risk of breast lumps anyway. Furthermore, the term 'breast lumps' does not refer directly to a medical condition as such. It works more as a kind of neutral description (within the context of a medical consultation).

After the patient say's "*I know*" (L14) the doctor continues with further cautions and is seen increase the risk by saying "*even some people will say cancer as well*" (L15). The reference here to 'cancer' can be seen to contrast with the term 'breast lumps'. As alluded to earlier lumps do not carry the same import that cancer does. A further feature of this utterance relates to the reference to 'others'. The words 'even some people will say' serves to construct enough facticity to provide the doctor's claim with 'external' corroboration but it is also vague enough to prevent undermining on the grounds of inaccuracy. This construction works to downplay the doctor as agent for the claim by relocating it to the medical voice in general and provides a warrant for the claim.

In response to a closed question in Line 8, the patient has gone from saying 'yes' she does check, to *'no not really'*, to *'no'* through to *'I do occasionally when I think about it', 'I don't think about it'* and finally to *'I do do it when I think about it'* (L9, 11, 31). These comments indicate the patient is not orienting to the health issues as the primary concern. Instead her talk is constructed to deal with issues of personal stake and aims to counter the doctor's formulation of locating risk and agency as the patient's responsibility and also resist the doctor's construction of risk talk as 'advice'. However, the doctor does not take the patient's responses as being sufficient as the matter is pursued with further advising between lines 17-32. There is a lot going on in this sequence but the main feature of interest is in how the doctor's talk works to negotiate issues of agency and responsibility for breast examination as a matter for the patient. This begins when the patient is told that she is the best person to know her breasts and this is followed with warranting that works to remove the doctor's agency. This functions to imply that doctors may not be the best people to detect/evaluate breast changes and works to circumvent medical responsibility and relocate this as a matter for

the patient. The doctor's talk is seen to provide a very persuasive rhetorical construction that has been difficult to undermine as on five consecutive occasions the patient responds with one word 'Right'. It is not until Line 31 that the patient provides what the doctor orients to as a rather weak attempt at further mitigation "*I do do it when I think about it*". Here the patient is seen to do some on the spot memory work and because the patient had previously said 'no' then this claim is less convincing. The doctor's response to this is to repeat what had already been said.

The analysis of Extract 2 has identified that the doctor constructed and located the responsibility for monitoring the HRT risks with the patient. The interesting point is that risk claims are, in effect, left to stand-alone. The doctor does not back them up using 'medical' evidence but warranty for the doctor's claims is strengthened with an externalising device of 'some people' to corroborate and provide consensus. As a result the patient has to do a lot of defensive work in presenting herself as a 'responsible' person. The effect of this is that the health issues under discussion are seen to take second place to the interactional concerns i.e. issues of risk and agency. The construction and action orientation of the talk in Extract 2 is seen to contrast with the formulation of Extract 1. Although both extracts present HRT reviews, variability was identified in the ways the doctor's oriented to risk. In the first extract the doctor was seen to attend to risk and agency as a matter for his/her concern. In addition, there was no direct mention of the word 'risk'. In the second extract the doctor was seen to use the term 'risk' on a number of occasions. Additionally, the risk construction was used to locate the patient as able to act agentically i.e. as the agent responsible for managing the risk.

The next extract involves a problem after it is reported the patient's blood pressure is 'up'. As was seen in the previous extract the doctor suggests postponing treatment. Unlike the previous extract, the patient is seen to challenge the doctor's decision to postpone treatment. The sequence continues from the point where the patient is informed of the raised BP.

7.5 Extract 3 D3LMF (Extract 3) 'When high blood pressure is not high'

1. Dr: Yea::h it's up a bit today
2. PT: O:h is it
3. Dr: Ye:ah (.) yeah
4. PT: Um (.) I saw Dr Richards when I was in and had it checked
5. regularly for quite a long time and we came to the conclusion
6. that I just probably had blood pressure that's quite high.
7. Dr: Mhmm (.) yeah it is (.5) it is up a bit (.) and I think all I
8. would suggest is that when you come back for your blood test in
9. Jan: well I think January would be fine for your thyroid
10. PT: Mhmm
11. Dr: is that we should em (.5) we should get your blood
12. pressure checked by the nurse at the same time em:
13. PT: It's tended to be high for quite a while now
14. Dr: Yeah (.5) I'm just wondering whether it's been high for
15. a while
16. PT: It has (.5) its always high
17. Dr: Maybe we should think about getting some treatment
18. to try and get it down.
19. PT: Right Right
20. Dr: I wouldn't do that toda::y.
21. PT: No.
22. Dr: I would suggest though that we do need to get you back to
23. see the nurse for some blood tests, urine test
24. PT: It is con: constantly high but I've had all the tests (.5) well
25. I don't' know if it's the same 24 hour urine collection.
26. Dr: Yeah. Yeah.
27. PT: and all that
28. Dr: (but this is a sort of bas: sort of again basic thing (.5) just
29. because you haven't had it done for a wee while)
30. PT: (But they were constantly high (.) on the high side)
31. Dr: (Can we pop you into one) of the rooms next door
32. Dr: So we can pop the needles in and leave you in peace

The patient is told her blood pressure is up and this is oriented to as news '*Oh is it?*' (L2). As was reported earlier newsworthy comments merit some form of assessment

(Jones, 2001). Here, it is likely that the patient's response to the news is seeking some kind of assessment from the doctor. This is not provided with the doctor's 'yeah, yeah' remark (L3) and the patient is seen to be the one to comment on the news " *Um, I saw Dr Richards when I was in and had it checked regularly for quite a long time and we came to the conclusion that I just probably had blood pressure that's quite high* " (4-6). This utterance informs the doctor that there have been concerns about the blood pressure in the past. What is interesting is that for some reason this information giving is constructed as a justificatory account for the news. It appears that the patient has oriented to an unstated request for an explanation.

A number of rhetorical strategies are activated within this account. First, it formulates the high BP as having a history and this carries the implication that today's high BP is not an isolated occurrence. Next, the doctor involved in the past is named. This serves to strengthen the account as factual and sets it up with the virtual presence of another doctor. In addition, the use of 'we' formulates a partnership between the patient and her (previous) GP. The use of 'just' implies that the blood pressure was not viewed as a serious concern at the time. This account presents the patient's first attempt at portraying the high blood pressure as the normal state of affairs. It also raises a potential problem, as untreated high blood pressure is not the norm.

The doctor responds with 'Mhmm' and without directly commenting on any of what the patient had just said moves on to inform the patient that nothing is to be done about the raised blood pressure today but that it will be re-checked by the nurse in January (L7-9, 11-12). At the beginning of this response it appears the doctor may still be responding to the patient's earlier '*oh is it*?' response.

During the remainder of the doctor's response, the course of action is formulated as if open to negotiation as it is only 'suggested'. However, the word *'all'* uttered immediately before 'I would suggest' can be seen to act as a kind of prefix and works to negate the notion that the course of action is only a suggestion. This leaves no room for negotiation as by implication the 'all I would suggest' works to close down the potential for other options to be available. As a result a decision is reached and agency for this is located with the doctor. The next sequence of talk involves four further claims from the patient for the chronicity of the high BP (L13, 16, 24, 30).

The patient's response *"It's tended to be high for some time now"* (L13) is her second attempt at constructing her concerns and this also serves to withhold agreement with the implicit decision over the course of action. The doctor is seen to orient to this with the comment *"yeah, I'm just wondering if it's been high for a while"* (L14-15). This response is ambiguous, as it appears to suggest that the doctor had not heard or taken up the patient's earlier implicit claim of concern i.e. that the raised blood pressure was not treated and had been viewed as the 'norm' for her.

The patient response *'it has, it's always been high'* (L16) provides an agreement with the doctor's prior utterance and is the third time her concerns have been raised. The deployment of 'always' is an example of what has been described as 'extreme case formulation' (Pomerantz, 1986). For example, when asked why they carry a gun people will often respond by saying something like 'everybody carries a gun' and thus, gun carrying activity is portrayed as a normal behaviour (Wetherell et al, 2001a p204). Pomerantz (1986) suggested that descriptions containing extreme points are a common and familiar practice. Wetherell describes extreme case formulation as a device to take,

whatever evaluative dimension being adopted, to its extreme limits (2001a, p204). On this occasion 'always' effectively maximises the patient's claim that the high blood pressure is 'normal' or 'usual' for the patient. The doctor does now appear to take up claim for the chronicity of the condition with the suggestion *"maybe we should think about getting some treatment to try and get it down"* (L17-18). The patient responds with 'right, right' and although this makes it clear that the proposed action is acceptable the doctor reports with "I wouldn't do that today" (L20).

The doctor's last two utterances (L 18 and 20) illustrate how the move between the deployment of 'we' and 'I' pronouns construct different rhetorical effects. Using 'we' is seen to construct an invitation for the patient to share in the 'thinking over' the matter of maybe getting some treatment. In contrast however, whilst the patient may be invited to share in that decision, the 'I' talk serves to exclude the patient from participating in the second decision over when the 'thinking about treatment' will be done. Here, the doctor has acted as the sole agent in making this decision.

Deploying the 'I suggest' device again (L22-23) the doctor informs the patient she needs to get some tests done. Once more, the directive contained in the utterance is formulated to appear as if non-commanding. The patient's response *"It is con, constantly high but I've had all the tests"* (L24) is the fourth appeal for the doctor to take up the patient's implicit concerns and works to challenge the decision. In response the patient is told "*but this is a sort of basic thing just because you haven't had it done for a wee while*" (L28-29). This talk orients to the patient's implicit disagreement and is formulated to do some justificatory accounting for the doctor's earlier decision. The presence of 'but' is seen to challenge and undermine the patient's last utterance. The use of 'just' also adds a further claim to warrant the decision by setting boundaries for the

consultation. However, the doctor's account is unsuccessful. For the fifth time the patient is seen to reject the doctor's justification and warranting by restating her BP has been high and 'constantly' high (L30). The doctor does not take up this appeal but brings the discussion to an end with an abrupt topic shift and the patient is asked to go to another room for acupuncture (L31-32).

This extract has presented an example of disagreement over the course of action proposed by the doctor. The patient was found to have raised blood pressure. Without discussing the medical consequences of hypertension (high blood pressure as a condition) with the patient, the doctor was seen to make the decision not to treat the condition at this time. This decision or course of action was formulated as a suggestion and thus, avoided a direct imputation of it as an 'order'. Agency for the decision-making was negotiated as a matter for the doctor. The patient was not given space to become involved in the negotiation.

The patient's concerns were formulated in terms of the chronicity of high blood pressure but the doctor's decision to postpone any active treatment did not allow her concerns to be taken up. The patient's five repeated claims of high blood pressure, in effect, constructed an indirect request for treatment to be started now. Although the medical risks of high blood pressure are not directly discussed the patient constructed her concerns around them as a warrant for treatment. Her construction was not taken up until near the end of the extract. Here, they were downplayed through the doctor's justificatory account that worked to imply that the purpose of the consultation was limited to performing a review of the HRT.

So far this chapter has examined the construction of risk and agency as a concern for the participants. In the first extract it was found that whilst there was no direct mention of risk, a risk repertoire was in play. Concern with agency was seen as a matter of the doctor's concern. In contrast, the second extract identified how risk was constructed to locate the patient as active agent having power over risk management. The third extract identified how a patient's concern over the decision to postpone treatment for high blood pressure was effectively put aside. Here, agency for the decision was located with the doctor.

The next extract has been taken from the first extract in Chapter 4 and forms the second part of a consultation where the doctor has proposed an increase in the anti-hypertensive medication. It was identified in the first part of this consultation that the doctor's justificatory accounting constructed to warrant a medication increase did not accomplish an unreserved agreement or acceptance. The doctor was seen to introduce a risk tool to further warrant a claim for an increase in the current medication regime. This extract begins from the point where the doctor introduces a computer software programme.

7.6 Extract 4 D4JFM (E2) 'If I cannot convince you the decision tool will!'

1. I could show you some (.5) I've got a computer chart I
2. could show you the difference (.5) lowering your blood
3. pressure a wee bit would make if you want to: (.) do you
4. wa:nt to have a loo:k at this
5. Pt: We:ll if you've got the time ha:ve y:ou
6. Dr: Aye (.5) I like my wee strange computer things (.5) this
7. is to try and anticipate somebody's risk of having a heart
8. attack or a stroke o:kay
9. Pt: A:ha
10. Dr: I don't know if I've shown you this before (.) what we
11. d:o is we put a:ll your details in here (.) so you're (.5) wha:t

12. now se:ven:
13. Pt: Seventy
14. Dr: Sixt: (.) you're sixty nine
15. Pt: Oh well I'll be seventy in June so:
16. Dr: Oh n:o we don't want to loa::d your (risk)
17. Pt: (o:h but I'm fi:ne (unclear overlap in speech)
18. Dr: (This is the one that will change (.) I mean:)
19. Pt: (Thats (.) thats) (unclear speech)
20. Dr: One ninety-five which is a wee bit up (.) so your other
21. blood pressure's good (.) you don't smoke (.5)(rustling paper)
22. cholesterol the last was (.5) (rustling paper) good (.5) three point seven
23. three is excellent (.5) HDL is one point four (.5) Diabetes and ECG was fine
24. wasn't i:t (7.) Yeah (.) Okay (.) so there's your risks (.) I don't know if you
25. can see them there (.) most of them are related to your age
26. unfortunately (.) but you (.) based on your systolic which is
27. the first value (.5) you've got (.) you've got a one in four
28. chance of having a heart attack in the next ten year
29. Pt: That's a good gamble
30. Dr: Well I mean you (.5) you'll be eighty at the time so it
31. sounds bad (.) but if (.) look (.) we manage to get (your blood:)
32. Pt: (laughter)
33. Dr: (pressure down) say to a hundred and fifty the risk drops from
34. (.) it drops about five percent but the other risks don't really change
35. that much (.5) so what we'll need to decide is really (.) you know
36. Pt: Ye:ah
37. Dr: I think we should probably increase the dose and see how
38. you get on (.) but if you get an:y side-effects from it then we'll
39. just cut back
40. Pt: I dinnae foresee that because there's nae problems at all wi'
41. it you know so (.)
42. Dr: Yeah (.) let me just double check the dose we can go up to
43. (.5) I think we're on quite a low dose to start with

The talk between Lines 1-4 constructs an invitation to use the computer chart. The doctor offers first to 'show' the patient the difference lowering the BP 'a wee bit' could make before rephrasing and asking the patient if he/she wants to have a look. This formulation works to show that there is room for discussion. The doctor is not going to use it without agreement from the patient. The doctor is not 'telling' but 'showing' the patient. Here 'showing' is constructed as less directing and more inclusive as it orients to a potential and implicit alternative construction of 'using'. Thus, it works to keep the matter open. Additionally, 'showing' allows the patient to see the 'evidence' for him/her self. Thus, the chart constructs a claim of objectivity for the evidence and it

relocates the doctor's agency for the claim and warrants the case for an increase. Here, the computer chart has been used as a form of empiricist accounting by providing an external and objective agent to corroborate the doctor's earlier claims for a medication increase. As the doctor had made the offer to show the patient and also checked that he/she wanted to have a 'look' (note again the word look contrasts with 'use') the agency of the chart in assessment of risk is up for negotiation.

The next sequence (L10-28) shows the doctor collecting the information required by the computer chart to establish the patient's risks of having a cardiac event over the next 10 years. The feature of interest here is in how the participants construct the patient's age. The doctor says "*so you're what now sevent*" (L12) but stopped before completing the 'seventy'. The patient is seen to either complete the doctor's utterance or report that he is 'seventy' (L13). However, the doctor responds with 'sixt' then tells the patient he is sixty-nine (L14). This repairing and reformulating may simply indicate that the doctor is doing the sums 'out loud'; nonetheless this does identify an interesting event. As is indicated in the comment "*Oh well I'll be seventy in June so...*" (L15). This quibbling indicates that the participants are orienting to an implicit matter over the difference between sixty-nine and seventy years of age. It appears that four months is of less significance for the patient than the doctor (the consultation was recorded in March). An explanation for the difference of opinion is provided when the doctor says "*oh no we don't want to load your risk*" (L16). The patient's response however orients to a problem with this comment. The response "*Oh but I'm fine*" is constructed to resist what the doctor had just said. The doctor does not pursue this implicit disagreement.

There is some overlap in speech as the doctor continues working through the computer chart and reports other risk factors and their significance (L20-23). This sequence contains medical descriptors (e.g. cholesterol, HDL, Diabetes, ECG) and numerical measurements. It is likely that this detailed information will not have the same import for the patient. The upshot comes when the doctor say's *"so there's your risks, you've got a one in four chance of having a heart attack in the next ten year"* (L24-28). There is an implicit assumption and possibly an expectation that the patient is following and will understand the significance of the tests and their results.

The construction of this description and explanation has attempted to provide warranty for the earlier claim that the patient is at greater risk of having a heart attack or stroke if the systolic BP remains at the same level. However, it does not appear to have been successful. The patient's response *"that's a good gamble,"* (L29) indicates that the odds given by the doctor did not sound bad at all to the patient. The next response from the doctor *"well I mean you, you'll be eighty at the time so it sounds bad ..."* (L30) suggests that the patient's last comment was not heard or oriented to in the same way

Laughter is heard from the patient as the doctor continues to report the 'statistics'. The patient's comment is not taken up and the doctor initiates a topic shift with *"I think we should probably increase the dose and see how you get on but if you get any side-effects from it then we'll just cut back"* (L37-39). The doctor has attempted to bring the justificatory negotiation to an end and moves on to begin to wrap things up.

The patient's response is seen to attend to the second part of the doctor's utterance, the 'side-effects' issue. *"I dinnae foresee that because there's nae problems at all wi' it you know so..."* (L40-41). This construction does not provide outright agreement but is

taken up as something of a neutral comment that serves as an agreement to the proposal. The doctor brings further discussion to a close by moving on to check dosage.

In this extract the analysis identified that the doctor's talk was constructed to provide warranty for an increase in anti-hypertensive medication. A risk tool was introduced to add further warranty with the help empiricist accounting and an external agent. One particularly interesting feature related to the haggling that took place over the patient's age. The rhetorical force behind the doctor's use and description of the risk tool was seen to be powerful and persuasive. The doctor introduced the chart to 'show' the patient and this worked to appear as less directing and constructed a picture of patient involvement. In effect, the agency for the evidence and risk claim was formulated as up for negotiation. An invitation was constructed so to offer the patient an implicit choice over the evidence provided in the doctor's earlier warranting for an increase and the 'objective' evidence provided later by the chart. This raises issues about how doctors use and 'share' technical information and language and the precision with which they explain risk and how this compares with the 'normal' population or state of affairs.

Extract 5 presents part of the discussion taking place over a specialist treatment for acne, 'Roaccutane'. The patient had made a direct request for a referral to the Dermatologist. The extract begins early in the consultation, after the case for warranting was made.

7.7 Extract 5 D6ARF (E2) 'Constructing treatment as potentially harmful'

1. Dr: Do you kn:ow what they would off:er you up at dermatology
2. Pt: No
3. Dr: The em (.) the main thing that they can do that we
4. can't is offer Roaccutane (.5) it's a very strong em tablet (.5)
5. basically that you take for three months

6. Pt: Mhmm
7. Dr: Em (.) you need to attend regularly and get regular
8. blood press blood tests if you're on it because it can cause
9. reversible liver damage (.5) so in other words they need to keep
10. an eye on your liver tests (.5)
11. Pt: Mhm:m
12. Dr: because if they start to go wrong they need to stop
13. the tablets (immediately)
14. Pt: (Mhmm)
15. Dr: and go back to normal (.5) but obviously if they
16. weren't measuring them if they didn't (know)
17. Pt: (yeah)
18. Dr: what was hap:pening
19. Pt: Ye:s
20. Dr: you know it could get badly damaged before anybody
21. would notice (.5) so it is reversible as long as you stop
22. the tablets you're fine but it is very strong treatment
23. Roaccutane (.) not only does it cause your sk:in to dry up
24. and the sp:ots to dry up but often it causes your mouth
25. and your nose and everything to get very ve:ry dry
26. Pt: Mhmm:
27. Dr: (h.h.h.h.) most people it clears their skin and they either
28. have no spots afterwards or it's much much better than it was (.)
29. the o:dd person (.) you know (.) it does come back.
30. Pt: Yeah
31. Dr: but the vast majority of people it is (.) it works really well for
32. but it does m:ean that you go through intensive (.) you know (.)
33. treatment (.5) it's very important that you don't become pregnant
34. on it because the Roaccutane can damage the baby
35. Pt: Mhmm
36. Dr: Em (.) as I say it's a lot of tests (.) it's a lot of monitoring a lot
37. of back and forward getting blood tests and things but the idea i:s
38. for the vast majority of people they get a good result (.5) they either
39. use roaccutane if your skin is very very bad (.) you know (.) you see
40. some people with horrendous skin
41. Pt: Mhmm

After being told the patient does not know what treatment he/she will be given at Dermatology, the doctor presents several pieces of information. This construction works as an outline or summary of the key issues over the proposed treatment. The main feature of analysis is in how this extract formulates an extensive account to account for the granting of the patient's request for Roaccutane treatment. The talk between lines 3-9 has been presented using the listing strategy described earlier. This helps to set out the various factors in a sequential order. Here the doctor reports that Roaccutane will be the treatment provided by the specialist, that this is a very strong tablet, and that the patient

will need to take it for three months and will need to attend for regular monitoring and blood tests. The point of interest here is that within the list each item implicitly orients to potential and alternative descriptions or claims.

First of all the drug is named. This works to exclude the potential that any alternative treatments will be considered. Second, the reference to the strength of the tablet formulates an implicit comparison with a 'milder' option. Third, the patient will need to take it for three months and by implication not only for a few days. Together the features and activities deployed in this sequence have constructed the practicalities involved in this treatment as a matter of course. It also has the action of presenting the information as an undisputable matter of fact. The medical orientation (both in terms of the language used and in the inferences that are made available for the membership category of doctor) provides this account with a strong claim to truth. In addition, the terms used in the information are packaged with an implicit evaluation e.g. potentially harmful. This implication however, is made clear and direct.

The patient is informed that the treatment under discussion '*can damage your liver*' (L8-9), '*cause your skin to dry up*' (L23-25) and '*can damage the baby*' (L34). Here the effects and risks of the treatment are constructed as being specifically relevant to the patient and not presented in terms of the general population. Furthermore, these utterances formulate a vivid picture of the effects and risks of taking Roaccutane. This formulation serves to leave the patient in little doubt as to what taking this treatment could mean for him/her. Edwards and Potter (2000) have described this effect as creating an impression of '*perceptual re-experience*' (p161). Besides this the formulation can be seen to indicate the doctor has particular skills of observation.

There is a variation from the 'individual' formulation when the doctor introduces a comparative case using the terms 'most people' and 'for the majority of people' (L27, 31, 38, 40). It appears that the claims for others work to strengthen the claim for the individual risks to this patient. Indeed, this description sets up the picture of it being more likely that the patient will experience these side-effects for him/her self.

Between lines 24-25 the doctor is once again using the listing device 'your mouth, your nose and everything'. The word 'everything' constructs an extreme case (Pomerantz, 1986) and this works to make the claim more effective. In addition, the doctor is seen to balance the account by presenting the positive and negative effects together i.e. its reversible, the skin and the spots will dry up but your mouth, nose and everything will get very, very dry. Here the doctor has not only provided the information but the 'risk' construction is likely to have a greater impact because of how it is formulated as serious or potentially harmful for this patient in particular.

The work involved in constructing risk claims is further pursued. Once again a three-part list is provided *'lots of tests', a lot of monitoring'* and *'a lot of back and forward getting blood tests and things'* (L36-37). Again the doctor has used a contrast structure to maximise the risk claims relating to the treatment with the repeated use of 'lots'. This formulation also helps provide a claim for the doctor as a disinterested party. The information relating to the treatment has been constructed with so much detail and successful claims for facticity that it is difficult to challenge or discount. The doctor's account, however, is not necessarily neutral. Rather, it is set up to warrant the claim for telling the truth, and agency and risk are constructed in terms of specialists and the many potential side-effects of the drug.

In this extract analysis has identified that the risk construction contrasts with other examples in this chapter. Here, risk is about the treatment regime itself rather than the prevention of a condition. The patient is provided with extremely detailed information relating to the effects and the health risks involved when taking Roaccutane. This detail is used to construct claims for facticity and truth telling. Familiar discursive devices were used to achieve the factual construction such as vivid detail, three-part listing and extreme case formulations. The deployment of these devices helped to set up the treatment as potentially harmful.

The doctor's account was seen to orient to the individual versus population dichotomy. In other words there was some to-ing and fro-ing between the general and the specific with regards to the patient as an individual and the general population. In particular, the repeated deployment of 'you' was seen to contrast with references to 'most people' or 'the majority of people'. The account was also seen to vary between formulating the effects as positive and the side-effects as negative. This served to create an impression of a balanced, value-free account and the doctor as neutral.

The next extract presents a discussion over the patient's 'viral' illness. In this extract agency and risk is constructed as a shared concern. The extract begins at the point where the doctor returns to a concern that the patient had introduced at the beginning of the consultation when providing the reasons for the visit.

7.8 Extract 6 D5CBF (Extract 2) 'Dispreferring the psychological'

1. Dr: So tell me about this fluey thing as well (.) We
2. kind of got side tracked there again
3. Pt: I know (h.h.h.h.) I don't know (sigh) I can't think
4. what else to tell you (.) I just feel so absolutely washed out
5. Dr: sore thro:at (.) sore ea:rs
6. Pt: Sort of (.) er (.) not so much down your throat (.5) more
7. like in your mouth
8. Dr: (Examining) Aha in there (.) mu:scles
9. Pt: No I just (.5) N:o I just I can:nae say (.5) just washed out
10. Dr: just washed out
11. Pt: and this funny horrible feeling in here (.5) like a panic thing (.5)
12. but just a horrible (.) and I had a long lie this morning cos this is
13. what I do when I'm going on duty and I got up and I thought (.)
14. God I was going to conk out (.5) and I've ha:d the flu injection
15. Dr: Well I don't know (.5) could it be an anxi:ety or (pa:nic)
16. Pt: (No I don't think:)
17. Dr: (I mean that's) a possibility (.5) have you felt ho:t and
18. shi:very with i:t
19. Pt: Well (.) yea:h I feel hot.
20. Dr: You feel hot and shivery
21. Pt: Cos I was sitting in that office waiting to go and
22. see the lady and I thought if I don't get up from this
23. heater I'm going to just flake out (.5) and I mean I don't fee:
24. I keep good health as you know (.5) I mean (.) just suddenly
25. feel (1.5) Yu::k
26. Dr: (Yuk like this (.1) it does sound a bi:t vi:rally doesn't it
27. Pt: Yeah (.) yeah
28. Dr: (1.) (h.h.h.) I guess it will come to a hea:d and get wo:rse
29. or it will go a:way (h.h.h.) which doesn't really help you
30. much but it does sound as if it is a virally thing and something'll
31. happen (.5) it will ei:ther get wors:e or get bett:er (.5) either i:n
32. the throa:t or it could b:e the sta:rt of a tummy bug or something
33. like that (.5) but ob:viously if things don't settle then shout (.) lets
34. do your blood pressure

Having concluded discussion over the other items on the patient's list of items to be addressed the doctor returns to the 'flu' concern. The feature of interest here is with the way this has been described, "*so tell me about this 'fluey' thing*" (L1). The construction of the condition performs several actions.

First, it indicates to the patient that the doctor has remembered what the patient had asked for at the start. Second, it is seen to match the patient's language by describing

the concern in the same way. Earlier the patient had described the concern as a 'flu thing'. This works to present the doctor as attentive and also the nature or status of the concern is not changed through for example, medicalised language. The action of this is that the concern is taken up for discussion on the patient's terms. Further, the addition of 'y' so that it is constructed as "fluey" serves to indicate that the status of the illness is in question.

As the patient responds to the doctor's invitation both participants 'together' are seen to explore the symptoms (L3-25). To begin the symptoms are located with the physical (e.g. 'washed out', 'sore ears', 'sore throat', 'muscles'). However, in Line 10-11 the patient introduces a different type of symptoms *"No I just I can:nae say just washed out and this funny horrible feeling in here like a panic thing"*. This talk can could potentially contradict and undermine the claim for a physical condition. However, it is non-specific. Using vagueness in this way the matter can be left open for further discussion and diagnosis and can "*provide just enough material to sustain an action without providing descriptive claims that can open it to undermining*" (Potter, 1996. p118). The patient has not blocked off or completely discounted the physical with claims for facticity (this would present with a greater potential to challenge accuracy), but the vagueness acts as a barrier by leaving room for it to be taken up again should this be necessary.

The words 'panic thing' sets up a picture of something more than just an 'ordinary' flu and works to maximise the patient's claims for concern. After the doctor's response *"Well I don't know could it be an anxiety or panic"* (L15) the patient talks over the

doctor and is seen to disagree with *"No I don't think"* (L16). Here it appears the patient has oriented to a problem in the doctor's suggestion.

The doctor is seen to immediately pick up on the patient's disagreement and this is repaired with the comment *"I mean that's a possibility. Have you felt hot and shivery with it"* (L17-18). The doctor returns to the physical symptoms. In this sequence both participants are seen to orient to the 'psychological' as a sensitive issue. In other words, the import from 'panic' or 'anxiety' appears unsatisfactory for the patient and this matter is taken up and repaired by the doctor. The suggested diagnosis is constructed to attend this further *"it does sound a bit virally doesn't it"* (note here again the 'y' on the end which serves to make a definitive diagnosis inconclusive). This diagnosing construction works to minimise the earlier imputation of the psychological without discounting the 'panic' completely and is necessary if the doctor does not want to be seen as dismissing this as a symptom. Here the participants can be attending to issues of stake and identity. Had the doctor made more of the psychological symptoms this may have been taken up as hinting at a mental health problem. Had the condition received an unambiguous physical diagnosis of e.g. virus, then the patients concern over the 'panic thing' would have been rejected. The doctor took up the patient's implicit concerns and formulated a middle ground option as a palliative and the patient's response indicates that this 'diagnosis' is agreeable *"Yeah Yeah" (L27)*. The remainder of this extract shows the doctor informing the patient of what he/she can expect and further discussion over the diagnosis is brought to a close.

Analysis of this extract highlighted that the participants used similar terms to describe and discuss the patients reported concern. The doctor's talk is seen to match the patient's lay views on the condition and medical jargon is absent. This talk may be

considered more patient friendly than some of the 'diagnostic' talk that has been visible in other extracts. Here, this was seen to make neutral the differences in status between the doctor and the patient. A problem over the claim for a psychological basis for the reported symptoms was also identified. The participants saw this as a sensitive issue. For the patient, the import from formulating the condition as psychological was unsatisfactory. The doctor was seen to orient to this by forming a diagnosis that was acceptable to both participants. In this way, both participants were seen to be attending to a dilemma of stake by formulating their interests as disinterested.

The next extract provides an example of a variation over the formulation of risk and agency when discussing viral illness. Here the patient is seen to construct claims for risk and agency as a moral concern and the doctor orients to 'risk' as a medical or scientific concern.

7.9 Extract 7 D1DLM 'Risk as a moral concern for the patient'

1. Dr: Okay ho:w can we help you
2. Pt: Well my throat ha ha (Right) it started er I think last week
3. and I just sort (.) and er (.) I mean I smoke and I'd been having a few
4. late nights and I just thought well it was down to that (yeah) but
5. especially (Right) this wee: (.) well yesterday and today it was
6. really painful (.) actually on Saturday (.5) round here and it's spreading
7. Dr: Right and:
8. Pt: Down there (down there) arm I don't think its related but
9. everywhere has their stakes whatever but a colleague of mine (.)
10. I've been working with (.) she's (.) was off for a couple of days
11. (Right) with the same sort of thing (Okay) but because I go out
12. working with people I just need to make sure it not (Yeah) too
13. contagious
14. Dr: Quite (.) okay (erm)
15. Pt: (er I mean the voice) isn't too bad today but it keeps
16. coming and going
17. Dr: Right okay (.) Mhmm em I'll have a look in the throat just
18. to see (.) you know (.) tonsils (Right) (1.5) Slightly swollen (.5)

have you been taking anything to help
Pt: Em I take medication anyway which is down there (right)
that's for something (yeah) completely different (.) I bought
some cough linctus from Boots (right) (unclear word) (coughing)
Dr: Nothing to help the pain (.) er Paraceta:mol (.) A:spirin gar:gles
Pt: No No
Dr: There might be something we could (.) you know (.) add in
let's have a look and see what there is to see (.5) open wide and say
Aaah (Pt: aah) a bit louder (Pt: aah) stick out your tongue a bit (1.)
Yep (.) that's fine and 'Aaah' (Aaah) (1.) yep
Pt: Sorry I can't:
Dr: That's fine (.) lets just check your glands (3.) and it just
started over the week:end d:id it
Pt: We:ll no (.) its (.) er (.) sort of Wednesday (.5) it just happened
it's keeping me up most of the night with a tickly cough (right) but
the pain it's in the neck side
Dr: Yeah okay I think what I would suggest is that the
(Pt coughing) likelihood that it's a (Pt coughing) viral illness (.) any
any: (.) you coughing anything up
Pt: Er yeah (.5) during the night its very mucousy but its mainly
clear just around here (right) I wake up and I can't breath and its just
a tickly cough and:
Dr: (Right)
Pt: (And I) blow my nose and generally that's fine
Dr: What sort of mucous is i:t (.) da:rk
Pt: No normally its just clear
Dr: Just kind of clearish (.5) do you have any medical conditions
gene:rally
Pt: No
Dr: No. (Right)
Pt: (I'm alright)
Dr: Right (.5) I suspect you've picked up a virus just from maybe
being a bit run down (.) exposed to other (.5) other folk and they can
give you pretty bad symptoms (.5) there's a few cases that I've seen
today actually with similar (.) similar stories (.5) irritant cough for
a few weeks so em in the first instance I would suggest that you
take um some dispr::in (.) you know (.) soluble aspirin
then gargle with it and then swallow it down so that would give
you some pain relief (.5) help the aches and pains a bit which are
fairly typical of an infection er (.5) viral infection and it should help
the throat as well (.5) You're not asth:matic at a:ll
Pt: No
Dr: No (.5) Em (.) so I (.) I would take that regularly as well (.5) so
I would (.) you know (.) be taking it three or four times a day
Pt: Right okay
Dr: Em and er (.) You (.5) on top of that you could also use
Paracetamol or Lemsips (right) which contain Paracetamol
Pt: Right (.) yeah
Dr: So that's what (.) so you can use both of them (.) em (.) as
far as the irritant cough goes you can try a (.) a (.) linctus

preparation (Mhmm) (.) Simple Linctus which should be available over the counter
Pt: Right
Dr: That's at the chemist (.) cough suppressant for an irritant cough
Pt: Right, okay
Dr: Er (.5) see how you go with that (.5) Night Nurse (.) Em (.) and I would just give it a few more days (.) Em (.) yeah (.) if you (.) if you any close contact with people if your coughing or breathing over them then you are probably likely to (.) to pass on (yeah) I think it (.) but it would have to be fairly close contact I don't think any (contact like this would:)
Pt: (a few of them have got) heart and lung conditions and whatever and (yeah) so:
Dr: That's (.) that's some of the clie:nts who are resid:ent
Pt: Yeah and I (.) like I (travel around a bit to see) them
Dr: (You travel around to see)
Pt: Yeah
Dr: Okay
Pt: Yeah (.) that's the bit I'm concerned about (.) (doing that)
Dr (Sure (.) Sure) (.) Yeah I suppose for the benefit of the (.) the clients (.) you know, it might be worth having a day or two off until you until you're over the worst of it
PT: Right
Dr: Em (.) if (.) if you could be spared tha:t is
Pt: Yeah
Dr: I think you know (and I (.) I think that)
PT: (I could just go in the office)
Dr: (would be the advice) just to be to be safe
Pt: Okay
Dr: Obviously if there's (.) you know (.) other circumstances which make that difficult doing (.5) (unclear few words) the risks are not that great (right) there is a potential risk you recognise that yourself(.) there isn't any evidence that antibiotics would be of benefit at this stage
Pt: Mhmm (.5) Right (.5) I just wanted to make sure that I didn't start killing people off
Dr: No (.) no no (.5) that alri:ght
Pt: That's okay (Coughing) Okay
Dr: Yeah (.) That oka:y Do you need some more aspirin?
Pt: Disprin?
Dr: Doesn't have to be Disprin
Pt: I've had this before and I don't think I got on too well with it
Dr: Right, well what:
Pt: I started taking soluble tablets before
Dr: Right (.5) Okay (.) well I would just stick with Lemsips then or Paracetamol and also to help the aches and pains you could take something like Nurofen (.) Ibuprofen (.) which is anti-inflammatory (that'll help) the pain as well
Pt: (Mhmm)(.) So it's okay to take them on top of the other tablet
Dr: Yep no problems whatsoever

119. Pt: Right

The patient has constructed an account that informs the doctor he/she has had a sore throat for several days. The patient has dismissed his/her initial causal attribution (e.g. late nights and smoking) as erroneous as the throat condition is becoming *"really painful"* and is *"now spreading"* (L1-6). Within this sequence the patient has formulated a warrant for seeing the doctor. Finally, this accounting provides the patient's expectations from the visit, *"because I go out working with people I just need to make sure it not too contagious"* (L11-13). This formulation works to introduce a moral issue into the interaction and makes available an inference that the claims are altruistic. This claim is difficult to undermine when using the 'weak' as a justification for seeking medical attention, as few would challenge a concern for others as inappropriate.

The request that the doctor could determine whether or not the condition is 'too contagious' is seen to orient to an implicit issue over sickness absence. If the doctor can confirm the condition as contagious this would provide the patient with the legitimacy required should he/she decide to take time off work. Conversely, should the doctor not provide this the patient will then become accountable for the course of action taken.

After examining the patient's glands the doctor 'suggests' that the 'likelihood' is that patient has a 'viral illness' (L35-36). The words 'suggest' and 'likelihood' constructs the diagnosis as tentative and implies there is still some doubt. The vagueness acts as a barrier to protect the claim from undermining and may orient to a tension found in

general practice[27] as it appears there is a lot at stake for both participants in the construction of viral illness.

The 'suspicion' that the patient has 'picked up' a virus is repeated (L50) and a justificatory account is constructed to explain how this was likely to have happened. This utterance indicates the doctor has settled on a diagnosis because of the presence of *"Right"*. Instead of perhaps qualifying the diagnosis with 'medical' reasons the doctor locates the responsibility for 'picking up the virus' to 'being a bit run down' and 'exposed' to 'other folk'. By way of further warrant for the claim, the doctor informs the patient of having seen '*a few case today with similar stories*' (L51-53).

After providing detailed information on how to take the suggested treatment, little space is provided for the patient to comment and ends with a topic change. The question *"you're not asthmatic at all"* (L59) works to invite consensus and effectively prevents further discussion. After hearing the sought after 'no' from the patient the doctor spends a considerable amount of time repeating the initial treatment suggestions but this time with more vivid description (L61-74). This detailed description can be seen to provide a 'taken for granted' background that had been set up with the earlier construction of viral illness and with the implications that could be taken from this. In other words, in spite of the variety of preparations named the decision has been made already. Thus, this vivid detail serves to maximise the warrant for the diagnosis and not particularly the justifications for symptomatic relief. The point is that there are no real options over the

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[27] Doctors appear to be faced with something of a dilemma over prescribing (or not) antibiotics for sore throats. This involves both the determining whether the condition is a result of a virus and whether or not sicker patients will benefit and the risk of complications will be reduced. One other issue relates to the impact refusing to prescribe antibiotics can have on maintaining the doctor-patient relationship. There has been a lot of research carried out to explore these issues. See Kumar et al, 2003 for an overview and update.

course of action available because the condition is attributed to a virus, and this works to refocus the concerns of the moment away from the diagnosis and onto the proposed treatments.

After providing the patient with information the doctor is seen to re-orient to the patient's expressed reason for the visit, i.e. to find out if the condition is contagious. The patient is informed that the risk of passing the condition on is low unless there is very close contact (L76-80). This comment is interesting because the doctor had, moments before, reported the condition as more than a one-off case (L52-54). This may have been heard as something of a contradiction by the patient as the next response does not grant unconditional agreement or acceptance. The patient is seen to provide a stronger claim for the risk by reporting that the clients have *"heart and lung conditions and whatever so"* (L80-81). Here the patient draws on the three-part listing technique to maximise on the implicit moral dilemma the patient is facing with regard to the 'vulnerability' of others. This makes available a general claim that all his/her clients have 'heart' and 'lung' and 'whatever' conditions without directly stating this and works to counter the potential charge that the account is inaccurate. The formulation has successfully resulted in orienting the doctor to the welfare of others and constructs the matter of agency and risks as being a concern for the doctor. The doctor is seen to pick up on this and suggests that the patient take a couple of days off (L88-90).

The patient responds with "*Right*" (L91). At this point the opportunity to resolve the 'moral dilemma' was made available and patient appeared satisfied. However, the next utterance by the doctor is heard to challenge the import of what had just been said "*Em, if, if you could be spared that is*" (L92). The warrant the patient was seeking has not

been given after all. There follows an overlap in talk when the patient offers a compromise by suggesting going into the office instead (L95). However, the patient appears to have wrongly pre-empted the import of what the doctor was saying. This becomes apparent after the doctor finishes off the utterance with *"that would be the advice just to be safe"* (L96).

Next, the doctor continues with some further risk talk. What is marked out as unusual however is when the patient is told *"there isn't any evidence that antibiotics would be of benefit at this stage"* (L98-102). It appears here that the doctor is orienting to an unstated concern. For the first time in the consultation antibiotics have been directly introduced. The patient had not asked for them nor had the doctor brought them out into the discussion as even a potential treatment option. Whether or not the patient had actually considered antibiotic treatment the doctor is 'reminded' that the patient just wanted to make sure that he/she didn't start killing people off (L102). This statement works to refute any implication that the patient had been looking for antibiotic treatment. This can be seen as defensive accounting and serves as a face saving device for a refusal to a request that was not directly made.

The key analytic conclusion in this extract relates to the patient's construction of risk and agency. This was formulated as a moral or ethical matter as opposed to a medical condition. The patient asked the doctor to establish if his/her condition would pose a risk to others. The feature of interest was with how 'others' were constructed as potentially vulnerable to infection. A second concern related to an implicit tension over the nature of viral illness and the efficacy of antibiotic treatment. It appears that the participants were orienting to implicit political issues with regard to legitimacy concerns

in being off work and antibiotic treatment. The doctor was seen to formulate the 'non' efficacy of antibiotics to provide further warranty for the diagnosis of a viral illness.

7.10 Discussion

This chapter has explored the construction of risk and agency as a matter of rhetorical concern for participants. The performative actions of risk talk were found to be varied and complex. In Extract 1 the terms the doctor used, to refer to risks, served to downplay risk and agency as a concern for the patient and, here, located these as matters for his/her own concern. Analysis of this extract also illustrated that machinery/technology can have a bearing on the interactional flow. The machine was seen to provide the doctor with an external agent that constructed a sense of objectivity. The concern is that patient's will lose out when this happens unless participants can be made aware of the performative actions of technology.

In Extract 2 during the review of HRT, risks were formulated as the responsibility of the patient. The doctor's information seeking appeared to be more a probing of the patient's agency in the matter of risk and was oriented to as criticism by the patient. The patient's contribution in the discussion was seen to respond these issues of agency and responsibility. This left the patient little room to contemplate the significance of the risks as a health concern and, raises the question over how much 'health' information and advice patients can take on board if preoccupied with the situated interactional concerns.

Extract 3 presented a discussion over the patient's high blood pressure. The feature of interest here was that there was no discussion over the health risks relating to the condition of hypertension. It is possible to assume that had the doctor provided this information then it may have been more difficult to warrant the decision to postpone treatment. The doctor did not concern him/herself in seeking agreement for treatment and so the omission of the actual risks as a medical concern helped to minimise concern and warrant the claim for postponing treatment.

A risk tool was introduced in Extract 4 to provide further warrant for increasing the medication after the doctor's initial claim was unsuccessful and not taken up by the patient. The chart was seen as an active agent in providing the evidence to warrant the proposed increase. One further particularly interesting event was the haggling that took place over the patient's age. Analysis showed that the difference between sixty-nine and seventy years of age had a greater significance for the doctor in terms of the 'risk' measurement and thus the risk category. This raises an issue over the 'impartiality' of evidence. No information was made available that would allow the patient to make a comparison with a seventy year old man who did not have hypertension (re having a cardiac event in the next ten years). The point is the evidence provided by the risk tool is not neutral but it provides a rhetorical claim for objectivity.

In Extract 5 risk and agency talk was constructed to attend to the doctor's identity construction of him/herself as a disinterested party. This was achieved in part with the lengthy factual accounting and 'truth-telling' that was made available from the description of the effects and the potential negative risks of the treatment. There was also an implicit orientation to the matter of the individual versus population dichotomy

and the doctor was seen to vary between using this to strengthen claims at different times for different purposes. The account's ability to present the positive and negative in a balanced way also worked to give the impression of neutrality.

In Extract 6 the patient had constructed his/her condition at times using vague descriptions. The feature identified was in how the 'psychological' was oriented to as a sensitive issue for the patient. The doctor picked up on this and successfully worked to repair any negative import.

In Extract 7 agency was cast in terms of a moral or ethical concern. The patient had constructed risk as a matter of concern for others i.e. in terms of passing on the virus as opposed to issues of risk to the patient's health. Here, 'others' were formulated as vulnerable, having heart and lung conditions. This implied the others were at an even greater risk, having 'serious' health conditions already. The participants were also seen to orient to implicit legitimacy issues relating to and of course the sensitive issue of taking time off sickness absence. A further concern was raised when the doctor introduced antibiotics into the picture to provide further warranty for the viral illness diagnosis. As a result participants appeared to be orienting to unspoken political ramifications over antibiotic treatment. This extract has illustrated how social and political matters can be subtly inter-twined with medical risk discourse.

In conclusion, the construction and action orientation of risk was seen to be varied and was formulated to perform a variety of rhetorical actions. On some occasions risk was constructed and located as the patient's responsibility, while at other times doctors were seen to formulate risk and agency as their own concern. These activities indicate that (in

the present study) doctors find more uses for the term and concept of 'risk' than patients do. At times the risk formulation appears to be expected to have the same meaning for patients as the doctors. Orientation to the ways risk is constructed as a matter of patient responsibility may have a bearing on the benefits of providing lifestyle advice and health promotion. It may be the case that attempts to raise patients' awareness of health concerns may be counterproductive in terms of both wider socio-political issues and local concerns relating to the doctor-patient relationship. This chapter has identified that construction of and the activities from risk and evidence talk is not a simple matter. It is only after analyses that the minutia of decision-making in terms of risk can be raised and ultimately addressed.

CHAPTER 8

Conclusion and Recommendations

8.1 Introduction

This chapter presents a brief summary of the background to SDM before moving on to provide a summary of the analytic findings and an evaluation of these. Next the theoretical and practical implications are discussed. Following on from this the chapter will reflect on some of the tensions within discourse analytic work and the implications of this for the status of DA findings.

8.2 Advocacy of shared decision-making

Shared decision-making is an approach to clinical treatment decision-making that contrasts with other approaches such as the paternalistic or informed choice models. SDM has developed from the recognition that the medical process needed to incorporate other aspects besides the traditional biological view of medicine such as the patient's worldview. The advent of the more inclusive 'biopsychosocial' framework for clinical practice led to a call for patient-centred medicine. Contrasting with the traditional doctor-centred approach, patients came to be placed at the centre of the medical process. The view that patients are an integral part of their own healthcare is now a firmly

entrenched ideology and therefore establishing a better understanding of the nature of the decision-making process is now a key focus for healthcare research.

One particular facet of medical practice that received less attention from patient centred approaches was that of patients' involvement in treatment decision-making. Once recognised as a crucial component of medical practice, the drive towards the shared decision-making approach has continued to increase in momentum. Recent developments have included the development of frameworks defining and determining the particular competences and skills crucial for engagement in this process (e.g. Towle and Godolphin, 1999; Elwyn and Charles, 2001) and an emerging literature on the ways these can be measured (e.g. Kiesler and Auerbach, 2003). As noted in Chapter 2 research has attempted to deliver instructions on process and outcome measures but these are unable to explain the actual process of accomplishing shared decisions. The nuances of the decision-making setting have remained unidentified and unexplored in spite of the drive to incorporate a shared approach to decision-making. In part, this is due to the methods traditionally employed to study the various facets of the medical encounter and their reliance on cognitive explanations that place decision-making within an individualistic mental explanatory realm rather than an intersubjective social practice one.

This study used a methodology relatively new to the field of research in general practice medicine although over the past 18 months of this study various forms of discourse analysis are increasingly being utilised in the medical consultation as the main method of analysis. For example, Nessa and Malterud (2001) used an analytic approach based on pragmatic and text-linguistic principles to explore concepts of patient autonomy.

from a single case study. Gwyn et al (2003) employed aspects of Bakhtinian theory of dialogism to explore a single case consultation to address medical risk communication and Werner et al (2003) used a feminist frame of reference, inspired by narrative theory to analyse 10 interviews from women talking about their experience of chronic muscular pain. The various analytic approaches used in the above examples clearly show a move away from the traditional methods of study and perhaps are part of a wider trend towards the increasing recognition of the value of qualitative approaches to study aspects of health and illness.

However, as far as has been established to date, the recent increase in DA work has not employed the particular analytic method used in the present study to potentially inform medical practice. In addition, neither has this method been used to examine talk at such a very fine-grained level before within the medical consultation. As reported in Chapter Two, the Discursive Action Model has more commonly been used to explore and describe, for example, community attitudes towards people with mental health problems (Cowan, 1994) and fact construction (Potter, 1996).

There appears to have been three main advantages in using DAM to explore the subtleties involved in treatment decision-making. First, it has provided a means of re-defining the medical consultation i.e. as a discursive event. Second, it has re-conceptualised the research questions traditionally asked of more conventional methodologies and has illuminated the process of interaction between the doctor and the patient. Third, as a result, the traditional view of the doctor-patient relationship (in cognitive or psychological terms) has been set aside in favour of, what is arguably a much more sophisticated kind of analysis, which can deal with the variability and

inconsistencies within the conversations that constitute medical consultations. Together, these factors allow for a new kind of examination of the doctor-patient interaction.

8.3 Key findings

In this thesis, three aspects relating to the activities involved when the doctor and the patient are intent on sharing treatment decisions were explored. The first analytic theme examined the construction of partnership and patient involvement in terms of the rhetorical activities arising from first-person pronoun use. The second theme examined the discursive activities involved when patients presented the doctor with a particular request. This theme also explored, in a very intensive way, the concept of patient involvement. The third theme examined the rhetorical construction of risk and evidence with a focus on the discursive location of agency. These three analytic themes can be seen to represent and provide a suitable analytic focus for key theoretical aspects or competences underpinning the SDM model. It is important to remember at this stage that all participating doctors had been trained in SDM techniques and were seeking to practise it in these consultations. The next section presents the main analytic conclusions for each theme.

8.3.1 Developing a partnership

Developing a partnership with the patient is listed as the first competency required for the SDM model of treatment decision-making (p31). To begin to accomplish a partnership the doctor is required to establish from the patient his/her preferred role in

treatment decision-making. The first point to note is that in the present dataset no occasions were presented whereby doctors discussed with the patients their preferences. Owing to this absence Chapter 5 charted an exploration into how patients' involvement in the decision-making process was generated through the construction of 'partnership talk' via the deployment of first-person pronouns.

Prior to analysis the use of first-person pronouns had suggested the doctor and the patient were seen to be working in partnership to negotiate and reach a decision. It was expected that the presence of the personal pronoun 'we' in place of 'I' worked to make the consultation less one-sided (doctor-centred) and more patient-centred. Therefore, when proposing treatments the use of 'we' was regarded as more facilitative of patient involvement in the decision-making process e.g. '*we could try this*' or "*what do you think about 'us' doing that?*". The formulation of statements such as these presented patients with an invitation to participate in the decision-making process as opposed to passively receiving 'doctor's orders'. The corollary is that invitations also suggest joint-activity and therefore, an inference is made available that an opportunity for 'sharing' was presented. Framing treatments as invitations would be seen to accord with the requirements of the SDM approach. It would be natural to expect then that this framing would facilitate patient involvement, independent from the decision reached. However, the analysis undertaken identified that the expected course of action described above did not always follow hand in hand.

The discursive features of 'partnership talk' and 'patient involvement' in the consultation were examined to explore the action orientation of the constructions and formulations of the decision-making. The performative actions of first-person pronoun

deployment were examined, as were the rhetorical formulations. This chapter identified that the construction of partnership talk (with no examples of either explicit or implicit presence of direct consideration of the patients' role) involved the deployment of a number of rhetorical devices by participants.

First-person pronoun deployment in the construction and formulation of treatment discussion was variable and ambiguous and was found to have at least three particular effects or actions: (1) doctors' 'invitations' worked to invite consensus, undermined patient resistance and prevented sharing, (2) doctors' 'invitations' facilitated sharing decisions and facilitated patient involvement, and (3) patients' 'invitations' led to partnership, autonomy and active participation.

The analysis identified that the doctor's use of first-person pronouns was seen to restrict opportunity for patients' involvement in decision-making. Owing to rhetorical ambiguity, pronoun deployment was found to help place the patient in the discursive position of either having to agree with the doctor or the more difficult position of having to reject the doctor's claims. Topic changing by the doctor at crucial moments was also found to put the patient in the position of having to either accept the doctor's attributions as a matter of fact or challenge the doctor's expertise. As a consequence, the patient was seen to have little choice but to align with the doctor. Aided by a number of discursive resources and strategies, doctors' first-person pronoun deployment worked to construct pictures of inclusion and partnership that helped to play down the absence of patients' direct involvement in the decisions whilst simultaneously masking imputation of coercion. In addition, doctors tended to treat the absence of comment or direct challenge from the patient as indicative of agreement and acceptance.

However, it must not be concluded that the formulation of partnership in terms of pronoun deployment is inherently flawed as such. As was illustrated in Chapter 5 there was some variability both in the actions of pronoun deployment and the formulations of partnership or patient involvement. There were two occasions where partnership constructions were seen to provide patients with the opportunity to participate in the decision-making process (e.g. Extract 4 p 117 and Extract 5 p 124). Here, 'partnerships' were seen as constructed products of the interaction that had been accomplished through pronoun deployment and a variety of other strategies and resources available to both participants. Notably, successful 'partnership' constructions were not a common occurrence however.

The analytic conclusions subsequently highlight a matter of asymmetry between participants in terms of power and control over the conversational space. Although attending directly to 'power' is not the aim of this form of discourse analysis (this would be within the remit of Critical Discourse Analysis) these factors definitely have a bearing on the interaction and the accomplishment of patient involvement or participation in SDM. In this study, 'power' is seen in terms of actual language use and embedded within the interaction. Power is not being read off what is said as if it were an extra-discursive phenomenon but rather, the process of power has been identified in terms of the ways courses of actions/decisions are decided and settled upon, through the mobilisation of particular discursive resources within the sequential nature of the interaction.

The analytic conclusions can be understood by looking at the rhetorical organisation and structure of participants' talk and, understanding talk as a construction that is set up to attend to alternative and competing versions. In this case, orienting to the idea that ordering or telling patients what to do is no longer acceptable. Doctors can be seen to have attended to this matter through the formulation of 'partnership talk' underpinned with the use of first-person pronouns and the construction of SDM can be seen to be set up to attend to the alternative position.

Based on the idea of competing versions then 'I' use may be generally accepted as more paternalistic. The apparent change in style from 'I' to 'We' may indicate that doctors have developed strategies using a range of resources that provide an appearance that they are not acting paternalistically. In a practical sense doctors may learn to 'talk the talk'. However analysis has identified that patients are still being directed with the traditional 'doctor knows best' approach and as yet doctors have not learned how to 'walk the talk'. To be able to do this, doctors may have to relinquish their power and perhaps they are not yet prepared to give this up.

A final point, however, is that it is not always a matter of making visible the workings of biomedical ideology that enlightens us to the activities, processes and accomplishments of the subsequent decision-making. Discursive analysis is more concerned with the identification and examination of the strategies and resources people use in order to provide accounts that will convincingly attend to their interests and without being undermined as interested. The variability in pronoun deployment and partnership showed how the doctors attended to their own interests in matters of SDM. In conclusion, the examination of the rhetorical use of first-person pronoun showed how

the construction of treatments or courses of action were seen to orient less to the medical matters but rather to the interactional matters or concerns at hand. Nonetheless, this does not remove attention or concern away from the rhetorical power in the surrounding talk i.e. biomedical ideologies. The use of 'we' instead of 'I' was seen to disguise and soften overt one-sidedness in decision-making.

8.3.2 The successful and unsuccessful construction of patient requests

Within the dataset there were a significant number of occasions where patients were seen to make specific and direct requests to the doctor. As was reported earlier (Chapter 6) making requests to the doctor are regarded as an uncommon event. It had appeared that in SDM consultations patients' direct requesting was perhaps more common or unique to this form of decision-making. Thus, it is possible that the SDM process may provide the opportunity for patients to request particular treatments or courses of action. For these reasons then, discursive analysis of this event was expected to be a fruitful exercise in terms of illuminating the discursive activities involved in the granting or refusal of requests.

The second analytic chapter examined the construction of legitimacy and warranting for requests and focused on how these constructions resulted in successful or unsuccessful granting. The analysis identified that the construction of legitimacy was raised as a concern for both participants. There were found to be three particular analytic aspects/themes to the discursive construction of legitimacy: patients' construction of claims for the legitimacy or doctorability of requests; doctors' formulation of refusal for

'illegitimate' or 'inappropriate' requests; the formulation of legitimacy as a concern for the doctors when granting requests.

First, patients formulated requests in terms of seeking expert medical authentication in a variety of ways using a number of rhetorical devices and discursive resources. For example, requests were set up in terms of lay knowledge of symptoms supported with external warranting and membership categorisation devices. The deployment of these and other discursive strategies were seen to help construct strong claims for the warranting of the requests and brought about prompt granting of the requests.

The second concern with legitimacy related to how refusals were formulated with a justification and warrant. The discursive formations and the process involved when refusing patients' requests were seen to contrast with the ways requests were constructed as successful. In the two occasions examined neither of the doctors actually said 'no' to the requests. Refusals were seen to be more difficult to formulate than agreements were. This finding fits in with those from conversation analysis, i.e. refusals are complex interactions and involve delayed responses, prefaces (e.g. '*Now*' Extract 7, L18), palliatives (*"It is a reasonable dose and the way that you are taking it, the auto-inhaler is a good")* (Extract 7, L52), and accounts. It appears on these occasions, the doctors are unable to 'just say no', and in order to legitimise refusals doctors were found to deploy and utilise a range of discursive resources. Doctors also aided legitimacy for refusals when matters of patients' concern i.e. 'worry talk' were not taken up. Had the concerns or 'worries' been addressed directly then the doctor claims of legitimacy for decisions would have been undermined and so to their power.. What was seen to happen on these occasions was that patients did not tend to disagree with or

challenge the doctors' proposals but instead aligned with and conceded to the doctors' decisions. This raises concerns over the second key feature of the SDM model i.e. exploring patients' ideas, fears and concerns over the condition and the proposed treatment. The question to be asked is what purpose is this done? It was apparent from this dataset that when the doctor 'knows best' there will be little room for the patient's worldview or lay understandings to be explored or taken onboard with the same weight that is given to the biomedical approach. As a result doctors here were not persuaded by the patients' requests. Whether or not the successful requests had stronger medical basis for granting than the unsuccessful ones was of no analytic concern. It appeared to be the case that successful granting was dependent on whether or not the patient was able to provide a strong case for legitimacy that could not be undermined if challenged. In the first 3 extracts of Chapter 6 the patients' request constructions were seen to leave little space for dispute owing to the rhetorical effectiveness supporting the claims for legitimacy. Thus, the legitimacy formulations are seen to be a key factor in securing success, first in terms of doctorability for the request and second for what the patient wants done about the condition or concern.

Successful construction for a particular treatment or course of action however, was not always accomplished with the same ease. In one example (extract 8, p169-170) the patient had made a request for anti-depressant treatment. The patient's legitimacy claim did not provide a strong enough warrant for the treatment. Unusually, this left the construction of a claim for the 'doctorability' of the problem with the doctor. As a result, the doctor was placed in a difficult discursive position and had to provide a justificatory account that would warrant a clinical diagnosis to support the patient's treatment request. This example showed a considerable variation in the construction of

successful requesting and the subsequent granting. The decision process here appeared to follow a pattern more commonly seen in refusals e.g. it was considerably lengthy and contained a considerable justificatory account that was ultimately supported through external warranting.

In conclusion, the analysis of patients' requests has identified a variety of ways requests can be discursively constructed to achieve successful or unsuccessful outcomes. The key analytic conclusion is that decisions surrounding requests are seldom related to medical concerns but are a product of the discursive activities and properties of the interaction between participants.

8.3.3 The rhetoric of risk, agency and evidence

The provision of evidence-based information on which to make treatment decisions underpins the modernisation plans of the NHS "to create health services which are patient-centred, fit for purpose, fit for people and fit for the 21st Century" (Department of Health, 2000; Scottish Executive, 2001). In terms of the education of healthcare practitioners the ability to provide patients with an evidence-base to help patients decide on and support treatment choices is claimed to be of paramount importance for patient-centred care. This has also been identified, as a key competence required of the SDM approach as, in order for patients to participate in decision-making, doctors are required to provide them with sound and impartial evidence. Chapter 7 explored this topical issue in terms of the discursive construction of risk and evidence and the subsequent construction of agency. It was noted that there was a considerable variation, both in the

ways these concepts were formulated and in the performative actions that arose as a result.

From the analysis it was identified that depending on the discursive concerns of the moment these three constructs can be formulated to produce a variety of actions. For practical reasons the analytic conclusions are addressed in terms of three themes although they cannot (or should not) be easily separated into discrete areas as they are interrelated features of the discourse and the interaction. These themes can be seen to relate to issues over information provision, the impact of technology and finally the form, content and organisation of language use when providing information and evidence.

8.3.3.1 Information

In general terms the analysis from extracts selected identified that on most occasions patients were either provided with very little information over the 'evidence-base' for treatment decisions or, were presented with information that was often vague and general. Not only did information provision omit to include all aspects of the medical concerns but also, it did not take up the patients' formulations of concerns. In addition, the doctor did not discuss the medical significance of conditions such as high blood pressure. It appeared that high blood pressure was often regarded as an acceptable and unquestioned side- effect of other treatments (e.g. HRT). Discussions over the medical risks relating to conditions or treatments were often downplayed or absent. For example, during the HRT reviews other risks (besides breast lumps or breast cancer) were not introduced or discussed e.g. heart disease, strokes, thrombosis and embolisms.

ovarian cancer. Although for some women the benefits of HRT may outweigh the risks, there was no discussion over the level of risk for the individual patients in this study. Downplaying risk and not discussing additional evidence enabled doctors to effectively rule out any sort of protracted discussion over treatment risks with the patient. One further concern relates to the fact that the menopause is not always regarded as a medical condition. It appeared that continuing with the HRT was taken as a given, in spite of real and potential risks to health (patients' blood pressures were up). There was no linking of the high blood pressures to the HRT. This begs the question of why the option of discontinuing the treatment was not raised.

8.3.3.2 Technology

The impact of machinery and technology on the interaction was found to have a variety of effects and actions. It was seen to disrupt the conversational flow and to silence participants (usually the patient). Doctors were found to give priority to the machinery and technology at the expense of attending to the patients' concerns. When found to be necessary for the doctor's discursive purposes, agency for the decision was more often located with machinery and risk tools or with the patient. In other words, doctors seldom constructed themselves as agents for the subsequent courses of actions. However, on one occasion despite the BP recording device reporting high blood pressure, the doctor was seen to refuse to accept the measurement as objective in order to provide a warrant for postponing decision to treat hypertension (Extract 1 p190). A further feature highlighted with decision tools involved the negotiation that took place over the patient's age (Extract 4, p212) i.e. the risks were not to be 'loaded' by entering the patient's age as seventy when still 'only' sixty-nine. This raises concerns over the

issue of impartiality with 'evidence' and also with doctors' constructions of a disinterested party.

8.3.3.3 Language usage

Some of the key features of interest raised here involved the terms used to formulate risk. For example, the doctor's construction of the medical risks involved in HRT as 'drawbacks' (Extract 1, p191, L 15) and 'breast lumps', 'breast cancer' (Extract 2, p202, L 13 and 15) were seen to minimise the medical risk as a concern for the patient. Patients were also seen to draw upon particular alternative positions to downplay their concerns (e.g. 'low mood' as opposed to 'depression' (Extract 8, p175, e.g.L70) and the negotiation and reconstruction over 'panic thing' (Extract 6, p222, L11). Here, the language use was seen to minimise the potential for negative inferences and helped to construct more positive self-identities for the patients. This analysis helped to identify how doctors can be seen to dip in and out of biomedical language depending on the discursive purpose. Patients too can be seen to orient to different inferences available from the variability in subject positions and identities that medical and lay discourses provide. The point of contrast, however, relates to the different actions that ensued from the constructions. In particular, the doctors downplaying of risk helped to prevent direct discussion over evidence and risk and instead provided warrants and justifications for postponing treatment or other courses of actions and the patients formulations were seen to attend more to matters of self-identity. A further variation of patient's orientation to self-identity was found in Extract 7 (p226). Here the patient had constructed the medical matters in terms of a moral risk, i.e. spreading infection to vulnerable others.

In summary, the results from the analysis in Chapter 7 identified a number of implications arising from the various ways risk and evidence can be constructed to attend to interactional concerns. The downplaying of risk raises interesting issues about the ways in which potential areas of concern, and even liability, are skirted around. The notion of 'evidence-based' practice can be seen to be at odds with the philosophy underpinning shared decision-making as it can be seen to retain the biomedical model as the dominant ideology (e.g. the effects of technical machinery, decision charts and the doctors alternating between lay talk and medical language). Evidence was not found to be impartial but can be formulated to provide an impression of this that subsequently allows the discourse of risk and evidence to be taken for granted.

8.4 Conclusions about the research problem

This section discusses the implications of this research for furthering understanding over the nature of shared decision-making in general practice consultations. The three chapters of analyses examined, what was thought to be, key aspects of this style of treatment decision-making: patients' involvement in the process, treatment options and the evidence-based considerations required of the models. The literature reviewed in chapter two identified that there is at present no reliable ways to measure outcomes or identify what aspects of the process are likely to lead to the accomplishment of shared decisions. Discourse analysis has provided a theoretical framework that facilitates an exploration of the process as a joint discursive production.

From the analysis, it can be concluded that the construction of partnership talk, using first-person pronouns, provided the speaker with a very successful rhetorical resource that works to retain control over the conversational trajectory. As a result, opportunities for patients to challenge doctors' treatment suggestions were rare. This raises a significant question over a hitherto, taken-for-granted assumption that because patients were 'invited' to choose, they were actually provided with a real opportunity to be involved in the process. With regard to the ways patients were seen to formulate their requests it was found that success was achieved because patients had oriented to the potential refusals. Requests were constructed using a variety of strategies that worked to head off refusals by making their claims difficult to resist. It could be claimed that the 'successful' patients were more assertive and had decided beforehand what their desired outcomes would be. However, from the discursive perspective, it is claimed that successful requesting was the result of the emergent properties of the interaction and not through being an assertive patient. These patients had warranted their requests by formulating strong claims of consensus and corroboration that prevented resistance by the doctor. The point being made is that these patients were unlikely to have decided before seeing the doctor that they were going to make their request because 'absent others' said they should. This strategy was made available and constructed within the interaction. Unsuccessful requests were found to be uncommon[28]. On the two occasions identified, refusals appeared to require much more work on the part of the doctor. This highlights an issue over the discursive opportunity to just say no. Refusals were seen to be indirect. This is not uncommon as 'good manners' can be seen to preclude this and potential conflict avoided. However, if following patterns of normative conversation, patients will be placed in similar discursive positions when faced with an 'option' to say

[28] Although implicit appeals for high blood pressure treatment/attention seen in Chapter 6 may be regarded as unsuccessful these emerged later in the consultation and as a result of medical reviews rather than direct requests.

just say no to doctors' suggestions. What can be suggested here is that patients will not be offered or afforded the same conversational space as doctors to provide a 'polite' but lengthy refusal. This may account in part for why patients were seen to align and concede to the doctor's invitations earlier (although, following this line of argument, even if doctors 'wait' for unambiguous and direct agreements and acceptances, patients may not be able to refuse outright anyway). There are implications then for participants when patients' treatment requests may be regarded as unsuitable or even potentially harmful. With this thought in mind, the final analytic theme explored the ways 'risk' and 'evidence' was constructed as a matter of concern for the participants. Here it was found that there were a variety of actions open, depending on the discursive concerns of the moment. Doctors were seen to use risk and evidence talk to attend to interactional matters of the moment (most probably orienting to time constraints). On many occasions matters of risk were downplayed or even omitted. This raises issues over the impartiality of evidence, impartiality of the doctor's agenda, and speculation over the patients' position with regards to their opportunity to assess risks and act as their own agents in the decisions affecting their health and healthcare.

8.5 Implications for theory

The main implication of these findings for theory identifies an issue over the goodness of fit between the theory and guiding principles (e.g. competences) underpinning SDM and putting these into practice. These frameworks provide list of competences for practitioners to follow, which in theory, should lead to the style of decision-making advocated as necessary in today's socio-political culture. The findings indicate that shared decision-making does not happen in practise in the ways suggested by the

models. There are two main points of interest resulting from this. The first directs attention towards the content of the SDM model and the second raises an issue over the SDM construct as a 'real' event in itself. These points will be addressed in turn.

After analysis began and only then, the concern over whether or not SDM was actually being practised was identified. Bearing in mind that the COMRADE questionnaire and semi-structures interviews had been used to establish the existence of SDM and to select best practice examples, there is good reason for thinking that the consultations were substantially more inclusive than average. There was no question or issue over the whether or not the GPs recruited for this study were intent on sharing the decision-making process with their patients. The reason for recruiting these GPs was because they had an active interest with involving their patients to participate in the decision-making process. In addition, before any discourse analysis each consultation was checked for indicators of SDM, such as option portrayal, in order to provide some practical help in identifying suitable extracts. This study also indicates that patients are satisfied with the decision process even when they do not actively participate in making the decision. The challenges to the existing models of shared decision-making are discussed below.

8.5.1 Portraying treatment options

Elwyn and Charles (2001) have argued that in order for a treatment decision to be truly shared then the patient has to be provided with at least two treatment choices. The

following quotation identifies the factors involved when offering patient choices of treatments or course of action.

> *The identification of choices is a critical part of 'sharing' decisions. It is well known that the range of options provided by the clinician will fundamentally determine the discussion and management decision. It may be that the choice to do nothing may not be presented, although it is recognized that patients often find conservative management presented as 'doing nothing' very difficult to consider... It is important as well to explore what options the patients feel may be available. Too often it seems, two or more choices are given from a biomedical menu, and little time is spent exploring what other strategies patients consider relevant.* (p 130)

There are four points to be raised over this statement. The first relates to the identification of choice. What is not clear from this statement is whether or not the authors mean that choices must be identified *by* the clinician or identified *to* the patient (or both). This would seem a necessary distinction to be made for professionals who are intent on an SDM approach. In other words, it will not be enough if it is only the doctor who is aware of alternative treatments. In terms of the analytic conclusions from the present study there were no examples in the dataset where the doctor provided alternative treatment options to the patient (nor was the option 'go away and think about it' suggested). This may be a key issue as it had been reported in Chapter 2 that there are likely to be two or more options available for treatment of most conditions (particularly for hypertension and the menopause).

The second point over option availability relates to the portrayal of treatment choice in terms of exploring ideas, beliefs and concerns about the condition or treatments proposed. What the analysis suggests is that the doctors did not often attend to patients' concerns. Rather than taking up the opportunity to explore concerns, topics were changed at crucial moments. From these findings it seems clear that professionals already have some awareness relating to the implications of attending to this 'competence', i.e. in terms of the medical agenda and time constraints. Thus, it is possible that there is a tension over the number of options that can be presented in a consultation when doctors are constrained by time. If this is in fact the case then this does not bode well for the SDM model, especially if patients have more than one item to address (and, as was found on a number of occasions, participants did orient to this as a matter of concern). Issues of time constraint and the length of consultations have long been identified as a problem and, in todays financially aware, and constrained health service environment, this issue remains at the fore.

The third concern draws attention to the 'absence' of professionals identifying 'doing nothing' as a legitimate option. Although Elwyn and Charles (2001) claimed that patients are reluctant to accept that 'doing nothing' is a 'real' option, they suggest that renaming this, for example as 'watchful waiting', works to reframe the issue into something more positive. The inference is that the reframing works to turn 'doing nothing' into a viable choice for the patient. Again, similar to the issues that were raised over option portrayal, this course of action was not presented to patients as a treatment choice, although it may have been implicit within the discussions and decisions over postponing treatment for high blood pressure. However, for patients to recognise that waiting may be a valid option, it may need to be made explicit to patients. Had doctors

used statements such as 'how about leaving this for now and seeing how things develop?' in theory, could have done this and, also could have opened up space for discussion. It has been claimed that patients attend their doctor with strong expectations of receiving a service (e.g. ten Have, 1995; Scott and Vick, 1999; Arborelius and Bremberg, 1992). Although it is likely that having the doctor make an assessment (about their illness or concern) may satisfy some patients, others will expect to be given a choice of active treatment. Crucially, if a course of action or inaction is not actually identified and expressed then the patient may not be aware that there is a choice. The patients in the present study were not given this opportunity.

The fourth point relates to the exploration of the patient's ideas about what treatments are available to them. According to Elwyn and Charles (2001), if the professional does not establish what treatment options think are available to them, then the patients will be offered a treatment from a 'biomedical menu'(p130). Essentially, this limits real choice and will ultimately close down any exploration of strategies patients themselves think might be relevant.

The overwhelming noteworthy event in the present dataset was that these patients were ***not*** provided with "two or more choices" and little or no time was spent exploring patients' fears and concerns or other strategies that patients might have considered relevant.

8.5.2 Equipoise

Elwyn and Charles propose that in situations of 'clinical equipoise' (a context whereby there are two or more possible directions or treatments to choose from) and the professional has no strong views towards any given option, the patient's view should be regarded as an important factor in the decision-making context. However, the authors have found that when patients are invited to participate they are reluctant to actually do so, with the usual response being that the decision is passed back to the doctor. This poses a clear problem for doctors who are intent on involving patients in decisions about their health and healthcare. It is difficult to discuss Elwyn and Charles' claims owing to the absence of examples of clear option portrayal in the present dataset. However, what can be said is that on many occasions when patients had attempted to formulate their concerns, the doctors in question avoided attending to them by moving on to deal with something else. Therefore, the conclusions from analyses would raise a question over whether or not exploring patients' ideas, fears and concerns is done on any regular basis in SDM.

The practise of option portrayal and equipoise has a significant bearing in terms of the study's aims to examine the nature of SDM. Analysis revealed there was a serious deficiency of option portrayal and conditions of equipoise in treatment discussions in the dataset. There were no clear examples or occasions where doctors presented and discussed more than one available treatment options. The nearest consultations came to attending to these crucial components was in presenting the patient with no option but reaching the decision to monitor the condition. There is no question that having available two or more treatments to choose from will not always be the case but to repeat, many of the medical conditions present in the data set have been regarded as ideal for clinical equipoise. Elwyn and Charles (2001) reported that the most influential

and effective characteristics of risk communication comprise two significant variables, namely 'treatment choice' and 'individualised (calculated) risk estimates'.

> *"The lack of professional equipoise perhaps makes it much harder to achieve a genuine partnership with patients who clearly have their own motivations and values. In these situations the professionals goals of risk communication may be at odds with the spirit of partnership and 'evidence-based patient choice"* (p. 150).

Although these aspects are recognised as key components in SDM consultations, the activities or processes involved in accomplishing the required competences have not been revealed by the present study. As reported earlier it is not simply a matter of following a framework. Analyses identified there were no situations of equipoise presented and the doctors' goals of risk communication did indeed appear to be at odds with the spirit of partnership and evidence-based patient choice.

This study can claim that doctors and patients were not able to accomplish SDM because: doctors did not establish what the patient's preferred role was; 'partnership' was very often asymmetrical and favoured the doctor; there was no evidence of option portrayal and clinical equipoise; exploration of the patients' ideas, fears and concerns was limited and often not taken up by the doctor (particularly with HRT reviews and high blood pressure). In sum, and in spite of the doctors' intentions to practice this approach, the competences required were not visible. However, stated intentions and doctors' ownership of the necessary competences are themselves a matter of rhetorical construction, possessing something of an imagined quality i.e. they are not a particular

pre-existing 'reality'. Excepting the patients who had made successful requests for treatments, it is possible that similar problems over patient competences arose. However, unlike the doctors involved in this study, the patients had not had preparation or training in the SDM approach. Thus, the doctors had a greater responsibility and were in a stronger position to accommodate this style of decision-making. For example, it will be of little consequence for patients to "*articulate health problems, feelings, beliefs and expectations in an objective and systematic manner*" (competence 3, p31) if the doctor does not respond in kind by exploring these. Additionally, if the patient cannot access information (competence 5 p31) they will not be able to evaluate it (competence 6 p31).

8.6 Summary

The issues and concerns that have been raised above could be regarded as fundamental flaws in the SDM approach, both in terms of theory and practice. On one level, the results of the investigation into the nature of this approach can conclude that SDM was not happening. These findings ultimately question whether or not the concept of decision-making is fundamentally flawed and asks if patients are able to assess this element of the interaction when they may have had no experience of contributing to decisions in this environment. If three days of training cannot enable practitioners to include patients in decision-making then how much more is required and indeed would more of the same be of benefit? Perhaps a more efficient strategy might be to improve patients' ability to make their expectations and requests more explicit? However, no informed shared decision making is possible until clinicians learn to present information without manipulating patients' choices. So the principal question now is: why is

involving patients as active participants in their health care decisions so difficult for general practitioners? Are they unwilling to do so, do they have insufficient time or resources (such as evidence based information) to allow it to happen or do they have insufficient skills? Perhaps this kind of partnership presents a threat to the traditional role of clinicians as 'experts', whose knowledge provides the legitimacy and power to control treatment decisions? These are not easy questions for the profession or researchers but ones that need to be addressed if we are to work out how to move to a more holistic and inclusive form of healthcare provision.

Other explanations for the analytic findings are available however. The next section presents an alternative account for the study conclusions and addresses the issue over the 'reality' of SDM.

8.7 Reflections and deflections

So far, the discussion over the results of the analysis has been more or less reported in terms of psychological or cognitive constructions. That is, the sharing of decisions (or not) has been explained in terms of an alleged mismatch between the SDM framework and the actual process of decision-making. In other words, the critique above has taken the view that the analysis has been a search for 'what happened' in the consultation, then asking 'why' and assessing this against the theoretical aspects or features of the SDM model. The reason for this assessment is because the model itself has been constructed with a particular sense of objectivity or 'reality' and through this 'shared decision-making' is represented as a 'real' or possible event.

Adopting this perspective however obscures one particular and very important question, what is meant by 'sharing'? The cognitive viewpoint would consist of an assumption/representation that the term 'shared' would have the same and enduring meaning and rhetorical function for all. This leads to a very blurred and fragmented picture as it omits the detail and complexity involved in the action of sharing. In other words, it does not consider that patients, doctors or researchers may utilise different meanings and understandings of 'sharing' at different times and at different locations. Sharing will be a situated practice and can be part of different discursive moves in different contexts.

In the literature review in Chapter 2, it was argued that the traditional methods of investigation into the doctor-patient relationship or interaction were underpinned by cognitive assumptions from the field of psychology. As a result, this perspective has produced a body of taken-for-granted assumptions and procedures that have been traditionally taken up as able to provide a particular sense of objective reality and explanations for causality. The underlying problem is that psychology has tended to examine people's talk or social activities abstractedly through the use of restrictive procedures such as questionnaires and categorisation processes such as content or thematic analysis. Questionnaires can be seen to restrict 'free-talk' and obscure complexities by limiting available responses and, sequences of talk from content analysis provide only decontextualised definitions, which are ultimately counted for frequency and generalisability. The results and findings from investigation using these techniques are ultimately viewed as pathways to understanding cognition. This can be regarded as the result of a failure to view language as the primary vehicle for social

action. In other words, language is viewed as an abstract categorisation system rather than as means of accomplishing social action.

Part of the task in the present study was to use an alternative method that could make the taken-for-granted assumptions inherent in traditional psychological approaches and practices more explicit in order to show how these provide the foundations of cognitive explanation for events. Subsequently, the analysis has identified that cognitive events and 'realities' are subjugated to the rhetorical construction of social practices and do not provide the same kind of results that are perhaps expected from traditional methods. What has been found is that the traditional expectations from research in terms of the conceptual understanding of the SDM setting may be at odds with the action-oriented nature of the everyday practices and talk that make up the doctor-patient encounter. The point to be made is that analysis has revealed and identified considerable variation in the decision-making setting in terms of the situated and functional characteristics of the discourses involved, and that this variability does not lend itself so easily to providing claims for generalisability beyond the exigencies of the interactional setting. Instead, by viewing the SDM consultation and the decision-making process as a constructed event and one that is constituted within the talk about it, participants are seen to formulate particular versions or realities in order to attend to their own interests in terms of the interaction and the performance of social activities. In other words, the analytic conclusions can be explained and understood in terms of a process that set out to identify and describe how participants attend to the medical matters at the same time as conducting important psychological business and managing dilemmas of interest. The key point is that SDM and decisions do not simply 'exist' but rather they have to be

constructed and thus, are emergent and constituted products and properties of the interaction.

The significance for claims of 'objective truth' over decision-making practices then can be seen to stand in critical contrast to the findings from previous work and the assumptions that underpin such work. The approach from discursive psychology can be seen to question the conceptualisation and practice of traditional approaches. However, the aim of this study has not been to undermine other approaches but rather to reconceptualise the questions traditionally asked of these in order to bring a new body of knowledge and information to the fore for further consideration. With this point in mind, the next section explores some of the more practical implications the analytic conclusions have drawn attention to.

8.8 Some general implications

Some readers of this work, particularly GPs, may view the analytic conclusions as a criticism of their work and perhaps as unfairly representing GPs in a somewhat negative light. The first point to make is that the doctors themselves are unlikely to have been aware of the performative action of their own or patients' talk. In the to-and-fro of discursive interaction it would be most unusual, if not impossible, to simultaneously focus on the constructed nature of one's constructions as well *doing* the actions that these perform. Conversation interaction has an always-present uncertainty built into it in which participants can never anticipate exactly how their utterances will be taken up. They are 'in-the-moment', so to speak, and cannot so easily escape the indexical properties of the conversational turns in order to attend to the constructive process itself.

Thus, the implications for doctors are at least two-fold. First, doctors may respond to the study with justificatory accounts to explain and defend their activities. Although this would (expectedly) fit in with everyday conversational practices and activities, it is hoped that this will not get in the way of reflecting on the study in terms of its practical and pragmatic conclusions in terms of their practises and consulting styles. Second, in order for this study to be of practical utility doctors will need to become aware of the action orientation side of talk and move from the traditional and solely representational view of language use if they truly want to invite patient participation. This suggests the need for them to acknowledge the normative rules of everyday conversation and reflect upon the rhetorical persuasiveness of particularly common turns of phrase or discursive strategies used as a matter of routine and which are offered and accepted as 'common-sense'. In addition, simply recognising commonly deployed discursive strategies and resources will not be enough in itself and practitioners will also have to focus on the 'production process' as well. The key to this in terms of the present study is teaching practitioners to recognise and accept that treatment decisions or courses of action are unlikely to simply relate to medical concerns but are occasioned and emerge from the situated interaction and therefore, will also be dependent upon other psychological or social business matters in managing dilemmas of stake or interest. A further crucial element to this is in getting doctors to relinquish power in order to achieve the change in current practice. This will require a whole systemic and societal shift and patients therefore will need to find ways to engage in this too.

It is not a case of proposing that doctors and patients should learn to become discourse analysts. Rather, by making participants aware that, over the course of what might

appear as 'mundane' consultation activities, participants will be working on at least two levels. One level will be dealing with the medical topic or concern under discussion and the other will be dealing with the business of formulating persuasive and plausible accounts to the listener. The point is that on some level participants are aware that what they are saying runs the risk of being challenged or even rejected. This is not necessarily because of how they feel or behave in cognitive terms but is evident in the action orientation of the talk. Raising awareness makes us take stock and think about how we do the business of social interaction. There will be a lot at stake for the medical setting if the social actions of talk go unheeded.

Further, the implications arising from the present study's findings may not only be specific to general practice. Besides medicine and medical practitioners there are a range of possible areas that could be targeted and influenced by the findings from this study.

For example, the broader political arena (such as the NHS and policy makers) will need to take into account what is actually happening when new policies aimed at social change (such as patient or public participation) are implemented. The findings from this study question the value of advocating approaches such as SDM. This concern needs to be considered by policy makers and economists as it will have implications for the NHS when the supplementary effects expected from partnership and patient involvement fail to materialise (such as improved commitment to treatment and increased patient satisfaction).

The findings can also offer practitioners in allied fields (such as nursing, clinical psychology and social work) the opportunity for creating and sustaining change in practice that can lead to greater patient or client participation. By raising awareness of how power imbalances can be situated and maintained through talk-in-action (and accepting that the constructive nature of language is the vehicle for getting e.g. the medical business done), provides particular information that can be used by other disciplines to transform communication skills training for those intent on involving patients, clients, stakeholders, the public etc more fully in the decisions and decision-making affecting their lives.

Finally, academic research could also benefit from being more critical of methodologies that serve to exclude the constitutive and constructive nature of language in use. This study has clearly showed that the application of theoretical frameworks in practice can be problem and the difficulties or constraints inherent in models such as SDM may actually be insurmountable. It might well be the case that the appropriate interventions for sharing and patient participation may not necessarily have their origins in academic research. The next section moves on to discuss some of the more specific implications and interventions that arise from the point above.

8.9 Implications for education and practice

In the main, current communication skills training programmes are based on and around cognitivist constructions (e.g. schemas and scripts) and do not take into account the performative activities of language use. As the clinicians involved in this study were not

demonstrating techniques that assist SDM there may be little value in promoting programmes of communication skills training such as the Therapeutic Alliance Model in student or postgraduate training.

In order to transform teaching programmes to take into account the notion that realities are constructed and constituted within talk, a different kind of focus is required for the teaching of communication skills. This focus will need to consider the social activities performed through and by talk and incorporate into the training programmes. One way to address this concern is to move away from settings that are artificially viewed as static. This will mean much more than simply moving away from 'laboratories', 'hypothetical scenarios' and 'frequency counts'. Rather, it means finding ways that can address and celebrate the indexical and constructed nature of meaning and knowledge. It is not within the scope of this study to provide an alternative to existing communication skills training programmes but it is appropriate to suggest that the findings from the discourse analysis may offer the potential for some forms of intervention.

Whilst DA research may not be straightforwardly applicable in practice it is within the scope of the present study to suggest that some of the findings can be of practical utility for educators, practitioners and patients. It is also perhaps more appropriate and pragmatic to ask which of the findings would be of most value for each group rather than asking what can be applied. To be able to do this it would be necessary to approach each group directly with the findings. Further work could be undertaken to address this but this is beyond the remit for the present study.

The next question would be to ask is what would be the best way to communicate the findings to each group in order to facilitate any form of implementation or application. Brief suggestions as to how future interventions could be informed for the three groups identified are offered below. Some of the interventions outlined above may in fact be appropriate all groups.

Education

1. Trainers and training programmes need to engage in new practices that are informed through the present study and other qualitative research
2. Training programmes will need to incorporate a social constructionist approach that will incorporate the indexical and situated nature of meaning, knowledge and understanding
3. Theoretical components of training could include an introduction to discourse analysis (to illuminate how dominance and power is constructed and maintained through everyday language use and conversational activities)
4. Identification and assessment of the competencies required by practitioners to provide the conversational space for active patient involvement is needed
5. Training 'sessions' could be analysed using DA to assess practical skills and further develop the skills necessary to recognise rhetorical strategies that close down partnership building opportunities

Practitioners and practice

1. Practitioners need to decide whether they want to practise SDM or not
2. They need to develop skills in self-awareness and particularly in recognising when their conversational activities are paternalistic
3. They should engage in questioning dominant ideas and practices in their everyday work
4. Continued professional development should also incorporate assessment of qualified practitioners' communication skills (similar to medical student and post-graduate training)

Patients

1. Need to decide on their preferred role in the decision-making (Do they want to be involved or do they want the doctor to decide for them?)
2. If they want to take an active role then patients need to develop the skills necessary for engagement and participation during decision-making
3. Patients need to be informed (and believe) that they have the right to participate in decisions affecting their health and healthcare
4. Patients could become more informed if non-academic mediums are used (researchers may serve patients more by presenting findings in less esoteric press)
5. The development of practical skills training programmes for patients in safe environments could prove beneficial

6. TV and other media could be used to present the public with illustrations of how to (or how not to) engage with their doctor in decision-making

The suggestions above may not be groundbreaking and many of these interventions are already being developed or refined. Further work is needed to assess whether the findings from DA can positively influence SDM practice. However, the claim being made for the potential value of interventions such as those above is, at least implicitly, supported by the findings from the analysis. Thus, it is possible that these interventions can be influential, both directly and indirectly, as a result of the new knowledge provided by this study.

This does not mean that a discourse analytic approach provides a panacea however. No matter what methodological approach taken, each will have its own particularly unique limitations. The next section offers a brief critique of discourse analysis. The tensions within this broad approach are explored in terms of the study's limitations. Here, the status of the analytic conclusions from a social constructionist approach is addressed.

8.10 Tensions in DA

This section briefly addresses and discusses some of the main tensions within DA. It begins by describing the two main contrasting approaches and their theoretical and philosophical foundations. From here, the conclusions of the present study are reflected upon in terms of the tensions described.

The simplest way to begin to address some of the problems in DA (and in order to avoid getting into a reflexive and philosophical spiral) is to begin by returning to two of the main strands of discourse analysis and the consequential underlying epistemological and methodological debate. By doing this it becomes easier to make clear the distinctions between approaches and to position the implications of these with the present study and its claims.

At the end of chapter 2 it was proposed that there were gaps in knowledge and understanding over the nature of SDM. These gaps or limitations were claimed to be the result of traditional enquiry being founded on cognitive and psychological methodologies. By definition, these methodologies hold a representational view of language. As a result it was claimed that traditional methods obscure the activities involved in talk and the processes involved in meaning-making and knowledge production. As part of the justification for the chosen method of analysis chapter 3 introduced and provided some examples of different discourse traditions and the types of analyses that is produced from them. Post-structurally informed discourse analysis (e.g. Foucault, 1972) was contrasted with more epistemological analytic approaches, in order to present the case for the suitability of an analytic method based on discursive psychological theory (e.g. Edwards and Potter, 2000). As outlined in chapter 3, the concerns for critical discourse analyses address the broad socio-political environment, and the analytic aim here is to identify for example, how power is constructed through discourses. The ultimate goal for this type of work is in stimulating political change.

In contrast to post-structural and critical discourse analysis, other approaches such as conversation analysis and discursive psychology adopts a more empirical and pragmatic

perspective. Rather than addressing broader political concerns these approaches examine the ways in which participants organise their actions in talk in order to co-produce understanding and thus, address talk and discourse at a more local and situated level. The goal for these approaches is to identify and chart the discursive resources and strategies drawn upon in talk and the resultant social actions these have. As a result different DA approaches ultimately seek to and will provide different kinds of knowledge. The next section briefly discusses some of the factors that are involved directly and indirectly in the kinds of knowledge that can emerge from different DA approaches and the subsequent status given to the analytic findings.

8.10.1 Contextual concerns

One of the key differences between DA disciplines relates to a variation over which aspects or features of talk should be considered as relevant social context. In other words, how much background information does the researcher need to analyse any particular piece of discourse? Schegloff (1992) argues that prior to and during analyses, researchers should consider both the distal and proximate contexts. The distal context includes features such as social class, gender or cultural settings. The proximate context includes the immediate features such as the occasion or location of interaction (e.g. a medical consultation or a police interrogation). Laclau (1993) describes these different contexts in terms of the discursive and extra-discursive, and argues that no clear distinction can be made between them, as they are all interwoven into the fabric of the interaction.

The views over what features define relevant context have sparked off some controversy in the field of discourse analysis[29]. The actual debate over context will not be engaged with here, having dealt with contextual relevance for the present study in Chapter 4. However, the deliberations over context, in some ways, can be closely related to subsequent concerns and conflicts over the validity or status of knowledge in social constructionist work. The concerns that have been identified as more particular to the analytic method used in the present study are discussed below.

8.10.2 The status of findings and issues of generalisability

As discourses are relative it may be claimed that there can be no objective or universal truths or understandings. This view identifies a particular criticism of DA and discourse analysts. That is, DA does not engage in the socio-political arena and issues are left unresolved and, thus, analysts are accused of sitting on the fence.

These criticisms can be strongly countered however. Whilst claims for overall 'objective truth' have been set-aside in the present study, the process of analysis enabled 'evidential' utility that has provided a sense objective truth. By analysing the data 'in the presence of the reader', the consistency of analytic conclusions can be evaluated by readers themselves. Further, the discursive patterns or features identified in chapters 5-7 were not created by my own cognitive judgements but rather these were illuminated through the participants' orientation to them. Concerns or pre-occupations with issues of generalisability and frequency counts were also set aside as ultimately analysis can never be complete or 'once-and-for-all'. Analytic conclusions never can be any more

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[29] To view this debate read Schegloff, 1997, 1999 and Billig, 1999

than one reading from a number of potential readings. This work provides readers with a logical, plausible and coherent analysis from which readers can make their own conclusions as to the value or status of the data and, the meaning and knowledge claims about it and contained within it. Concerns with the search for objective truth do not preclude the findings from providing new information and knowledge that has the potential to stimulate change in general practice.

The second matter that needs to be addressed relates to generalisability. If analytic conclusions can only be regarded as indexical and situated then there may be a question over the degree to which findings can be generalisable. This is a claim that is sometimes used to undermine the value of DA work (for example, where the extra-discursive context is not considered relevant unless participants orient to it themselves, such as in conversation analytic approaches). Here, questions can be raised such as 'Which version or account offers the closest claims for truth?' 'How can findings be of practical utility if meaning is constituted in and constructed at the site of production?

For this study, the response to questions such as those above is that this research did not aim to seek objective or absolute truths. Rather, the aim was to identify and explore the ways in which truth is produced by and constituted within the claims for it. This should not mean that the findings are redundant however or have no use outside of the occasioned setting from which they are based. It is still possible to generalise but the basis for doing so will be different (Taylor, 2001 p13). Whether or not the same conversations will ever again occur in the same way is not the issue for this study. What can be made generalisable are the patterns of discursive activities within these doctor-patient interactions. These can be used as examples of how speakers co-ordinate their

conversational activities by drawing on common knowledge that is shared by members of the same culture in order to perform specific actions and serve specific functions.

Patterns of practises using particular discursive strategies and resources have been made visible through analysis that can be utilised across a range of contexts, such as counselling sessions or court room talk. Thus, the conversational activities identified in the data presented in this study are likely to be present or available to participants over a range of social situations. However, the performative actions (or the business being done by the talk) in the SDM setting will have different consequences and implications for other settings, but will remain unique to the specific site or occasion.

The findings in the present study can be used to make a claim for generalisability in the SDM setting particularly and, across GP consultations in general. The findings may also be useful to other contexts where decision-making or choice is a key feature of everyday activities, such as in management or education sectors. Features of interaction have been identified which, have the potential to facilitate more self-reflective and critically aware engagement with the world by its participants. The analytic conclusions also suggest that socio-medical approaches like the SDM model may be bankrupt outside of the particular encounter. That is, discourse analysis has showed the fine details of how SDM fails to operate in situ by illuminating how decisions are practical accomplishments that are managed in the flow of conversation. These findings may also have a wider relevance for other arenas that rely on models for teaching and learning. Before bringing this thesis to an end the next section presents a brief discussion over a further contextual concern encountered in this study.

One other challenge faced in this study was on a more personal level. This involved me trying to construct a kind of common ground approach between the different academic disciplines involved and addressing some interactional barriers to this. Not only was the study set in the field of medicine but it was also to adopt a qualitative method of analysis that was at best described as coming from social psychology and at worst, described as being 'on the margins'. As there were two different discourses at play here (and consequently different issues at stake for each discipline) it was a struggle at times to reconcile one with the other. As the different disciplines could be seen to hold different ideologies and thus competing views over how the study was to progress, it was difficult to construct a thesis structure that was acceptable to both. The first step in overcoming these difficulties was by learning to recognise for myself the different discourses at play and the powers wielded by each. This difficulty was gradually overcome through becoming a discourse analyst myself and also with the help of significant reflection and self-awareness. The next step was in finding a practical way to reconcile the different discourses and expectations. Progress was hampered until I began to develop the necessary confidence in both my research abilities and in my abilities to make the study my own.

To conclude, I have made this thesis as inclusive as possible with regard to the different expectations from within the social psychology tradition and the health service research (HSR) discipline. This goal was reached by achieving the 'gold standard' expected by the different research approaches. As a result, this thesis presents a trans-disciplinary approach to the study of the medical encounter and it provides some bridge building between different fields. The new knowledge and information generated should be useful to both disciplines. For example, it offers the medical field a new way to look at

the doctor-patient interaction and it poses questions for social psychology relating to the practical utility of research findings. In other words this trans-disciplinary study moves the work out of subject-based allegiances and into the world of practice.

Appendices

Glossary

In the main the following glossary has been constructed from following web site. Further additions to the glossary cite appropriate references. http://www.psych.auckland.ac.nz/psych/pgrad/PGCourses/743/PSYCH%20743%20glossary.html.

Action orientation: In relation to talk or texts, assumes that language is used 'strategically' to achieve specific effects or ends. This strategic use is not necessarily 'conscious' on the part of the person using the language.

Agency: The possibility of choice in a situation in which there are contradictory requirements provides people with the possibility of acting agentically. The personal psychological features of agency, constitutive of free will to the social, relational aspects of agency constitutive of political freedom (Wetherell, et al. 2001a p270).

Constitutive: Relates to reflexivity. The 'sense' that events are in part, constituted by the description. Reflexivity draws attention to the combination of being both *about* and *part of*. (Potter, 1996 p47)

Constructionism: a broad theoretical framework (under which lots of more specific approaches fit) that sees the world and what we know of it to be constructed through various discourses and systems of meaning, rather than being naturally or inherently true in any acultural, ahistorical sense. The terms in which the world is understood are seen as social artefacts, products of historically situated interchanges among people, and as such, are social, cultural, moral, and political. Features of a constructionist take on the world within psychology include the absence of an ultimate truth, and the understanding that 'knowledge' and 'truths' are constructed and sustained through language, linguistic resources, and social processes within linguistic communities. A critical or sceptical stance is taken regarding perceived 'truths' and taken-for-granted

knowledge. Such an approach is typically seen as anti-realist, anti-essentialist, focused on interaction, social practices, and processes.

Conversation analysis (CA): a type of qualitative analysis concerned with analysing talk-in-interaction, looking at the way language is designed to produce effects, and produces effects – how meanings and actions are produced and negotiated by participants in an interaction. For CA, analysts should not look outside the text (interaction) for anything that is not a participant's concern (i.e., is something the participant takes note of in their talk/interaction). A CA analysis is very technical and detailed, and the preferred data are 'naturally occurring' (e.g., taped phone conversations, rather than interviews).

Deconstruction: a critical form of analysis (and a philosophy), which aims to interrogate a text to identify the assumptions on which it is based. The categories and strategies used to produce particular versions of reality are identified and problematised. Deconstruction can be used to reveal hidden or marginalized meanings and shows meaning to not be fixed or singular, but rather multiple and up for negotiation.

Discourse: a word with various meanings. 1. It can be used to refer to talk and textual materials (e.g., newspaper articles, policy documents), but tends to focus not purely on the words themselves, rather on these as part of *practices*. 2. Another common meaning is much broader, and is found in much poststructuralist work. Here, discourse refers to systems of meaning and talk, which cohere to form a readily identifiable way of interpreting or understanding a particular object, or set of objects, in the world. A discourse is a socially and historically viable way of specifying truth and knowledge, and it brings objects into being. It is organised and sustained (and resisted) by talk and action. Within this interpretation, some discourses are dominant and seem to be 'common-sense'. These can be used to explain, allow, and promote certain behaviours, and to limit others.

Discourse analysis (DA): again, there are different types of discourse analysis. 1. It refers to analysis of talk or texts and focuses on the sorts of resources that people use to perform actions. 2. It refers to the analysis of texts to identify broader systems of meaning that construct meaning: informing what is said, and what makes sense. Discourse analysts analyse anything from tape conversations to media texts.

Discursive psychology: discursive psychology offers a perspective on psychological life that focuses on analysing accounts, which are not seen as secondary to the real event, but as constituting it. Language is treated as functional – it does things – rather than neutrally descriptive – a window to a person's inner truth. But like other topics, there is debate about what discursive psychology actually is. Critical discursive psychology (drawing on Foucault) looks at how language works – producing the world, and infused with ideology, power etc. Other discursive psychology looks at the ways psychological phenomena (like attitudes, attributions, memory) are created through talk and interaction, rather than treating them as an inherent part of individuals. It is discourse, conversation and rhetorical analysis applied to psychological notions and categories.

Empiricism: sees truth as revealed through observation and experimentation/research – the use of empirical methods. Within such paradigms data is seen to lead to scientific knowledge, which is seen to lead to the truth.

Grounded theory: a methodology that offers a way of developing theory grounded in data, which are systematically gathered and theorised. As the theory evolves throughout the process of the research, data analysis and collection are linked.

Indexicality: the idea that meaning is indexical is that it changes as the occasion changes, and as it is used in different situations. So, meaning is not something independent of context and use, but depends on user, context, etc.

Linguistic philosophy: Problems of knowledge were reworked as problems of language and, specifically, as problems that could be fruitfully recast in terms of language use (e.g. Austin, 1962; Wittgenstein, 1953) Edwards and Potter 1992, p27

Medical gaze:

A concept employed by Foucault to denote the power of modern medicine to define the human body. (Bilton et al., *Introductory Sociology*, 3rd edition. London, Macmillan, 1996:664)

Positioning: The process by which subject positions are mobilised through talk.

Positivism: a way of making sense of the world/doing research which recognises the positive facts and observable phenomena – and is concerned with identifying laws which determine things, and the relations between things. So it assumes a world that exists independent of our ways of getting to know it, and science and objectivity are seen to lead to the truth/facts. The research project is seen as cumulative and progressively getting us closer to the truth. The ideology of positivism is hidden behind the rhetoric of bias-free science.

Postmodernism: is notoriously resistant to definition (and anti-definition in itself). Broadly speaking, it is an approach to society and/or knowledge that stresses the uncertainty of knowledge and organisation, the multiple truths that exist, and the disintegration of an authentic individual self. It is often seen as ironic and self-aware.

Poststructuralism: refers to a loose collection of theoretical positions (and analytical approaches), which developed from structuralist theories of language. The different approaches labelled poststructuralist share assumptions about language, meaning, and subjectivity. Language (discourse) is seen as constitutive of the world, social organisation, and subjectivity. Meaning is thus constituted within language and discourse.

Power: within feminist and critical research, an awareness of power is essential. This includes the power the researcher has over participants in the research (although this varies), as well as (often) the workings of power within society.

Realism: an ontological position that assumes that the world has a true nature, which is knowable and real, discovered through experience and research.

Reflexivity: reflexivity has many meanings, but here it is concerned with a critical reflection on the research, both as process and as practice, and on one's own role as researcher. Reflexive research involves an awareness of theoretical assumptions and how they shape and limit the research. It also involves an awareness of how the research is conducted, and the methods used, and the impact of these on participants. Finally, the reflexive researchers are critical about their own self-involvement, the ways they implicitly and explicitly shape the research.

Reflexivity 2: is the property of talk whereby it constructs or otherwise contributes to the sense of it's own occasions and contexts. The notions of reflexivity and indexicality are closely connected. (Potter 1996, p47)

Relativism: an ontological position which states that we can never know the true nature of the world, that all we have is accounts of what this is, and that, at least epistemologically, these accounts are all theoretically equal.

Reliability: A key component of quantitative/positivist science – 'good' (i.e., 'true') results depend on their ability to be replicated. Qualitative/critical approaches do not assume that with repetition, the same 'results' will be achieved, and that this would be a measure of success.

Rhetoric: a feature of the antagonistic relationship between versions: how a description counters an alternative description, and how it is organised, in turn to resist being countered. It is close to the traditional notion of 'suasive' rhetoric, which is discourse designed to elicit expressions of agreement from an audience (Potter, p108).

Subject Positions: 'ways of being' that are offered or afforded by discourses – which individuals (subjects) take up, resist, etc. They offer ways of making sense of oneself in relation to the world, activities, identities, etc.

Subjectivity: is the conscious and unconscious thoughts and emotions of the individual, sense of self and ways of understanding the self in relation to the world. Within poststructuralist (and postmodern) thought, the rational, unitary subject/individual with an inner essence (the subject of humanism) has been replaced with a contradictory, fragmented subject, constituted in and through discourse. Poststructuralist accounts of discourse see that discourses offer 'subject positions' which offer individuals identities and enable particular actions.

Thematic analysis: a form of analysis which has the theme or category as its unit of analysis, and which looks across data from many different sources to identify themes (it is similar in this way to content analysis).

Validity: Like reliability, this concept is a key feature of quantitative/positivist approaches, but refers to whether what the research is actually showing what it claims to

show. And again, replicability (of the same results, with other or the same measures) is a key feature. Qualitative/critical research aims more for 'specificity', and ecological validity, which is achieved when meanings of the research setting itself are explored – the role of the researcher etc and their assumptions and how these affect the analyses should be made (reflexively) apparent.

Data Collection Records

Table 1 Data collection records

Table 1 includes the number of recorded consultations for each doctor and mean COMRADE scores. The numbers of patient refusals (declining to participate in study) for each doctor are included as is the number of patient interviews carried out. On two occasions patients were interviewed whose COMRADE scores were lower than the overall mean for the GP concerned. This resulted from the necessity to interview patients within the shortest time frame following the consultation. Scores from the study by the authors of COMRADE were used as a baseline for the present study.

Table 1 Sampling details for each GP

GP	SEX	Recorded Consultations	COMRADE Mean Score	Refusals	Interviews
1	M	28	82%	15	8
2	M	24	86%	14	7
3	F	19	89%	8	6
5	M	14	96%	8	3
4	M	10	86%	5	4
6	F	15	86%	5	5

Table 2 Numbers of male and female consultations and interviews for each doctor.

Table 2

GP	Patient Sex		Patient Interviews	
	Female	Male	Female	Male
1	20	8	5	3
2	14	10	4	2
3	16	3	5	2
4	12	2	2	1
5	5	5	1	3
6	12	3	3	2

Table 3 Patient demographics.

Includes patient age, sex, COMRADE scores and whether or not interviewed. Missing data indicated by MD.

Table 3

ID	Patient	Sex	Age	COMRADE	Interview
1	JS	F	75	72	NO
2	ES	F	61	51	NO
3	DL	M	30	93	YES
4	BMC	M	22	97	NO
5	OB (CHILD)	M	MD	83	YES
6	PA	F	32	82	NO
7	MF	F	MD	89	NO
8	CV	F	31	100	NO
9	NMC	F	MD	54	NO
10	JL	F	21	100	YES
11	MF	F	74	83	YES
12	LGM	M	82	81	NO
13	DF	M	14	85	NO
14	IG	F	71	95	NO
15	MDB	F	62	96	NO
16	JW	F	37	99	NO
17	SMC	F	63	99	NO
18	RS	F	46	90	YES
19	JL	F	36	87	NO

20	SP	M	31	88	NO
21	AM (CHILD)	F	MD	84	NO
22	NA	F	62	100	NO
23	EC	F	65	97	NO
24	LL	F	74	69	NO
25	GA	F	58	63	NO
26	JP	F	28	85	YES
27	EC	M	68	86	YES
28	GT	M	46	97	YES
29	CB	F	66	90	YES
30	JRT	M	66	100	YES
31	TV	M	61	97	NO
32	AS	F	63	98	NO
33	AS	M	38	87	NO
34	AE	F	67	97	NO
35	RD	M	46	88	NO
36	LM	F	52	100	YES
37	MS	F	74	100	YES
38	RMC	M	63	80	NO
39	MR	F	30	100	YES
40	CG	F	51	99	YES
41	BF	F	30	96	NO
42	MB	F	70	100	YES
43	MMC	F	61	100	YES
44	MM	F	70	100	YES
45	HW	F	MD	96	YES
46	KM	F	47	80	NO
47	GM	M	44	86	NO
48	SS (CHILD)	F	MD	61	NO
49	JMC	M	43	59	NO
50	AS	M	65	100	NO
51	DGW	M	36	93	NO
52	BK	M	61	95	YES
53	CB	F	72	98	YES
54	SL	F	50	93	YES
55	AW	F	54	98	YES
56	VS	F	50	100	NO
57	IT	F	56	100	NO
58	SL	F	MD	80	NO

59	TM	F	33	66	NO
60	JM	F	59	100	NO
61	MMC	F	19	97	NO
62	AR	M	65	96	NO
63	DL	F	44	80	NO
64	LF	F	37	76	NO
65	CK	M	39	84	NO
66	HB	F	58	100	NO
67	TM	M	56	100	NO
68	AW	M	MD	97	NO
69	JR	M	46	99	YES
70	JL	F	82	100	YES
71	HE	F	68	98	NO
72	CL	F	31	100	NO
73	NR	M	34	80	NO
74	MR	F	29	72	NO
75	SR	M	23	88	NO
76	LR	F	33	86	NO
77	PT	M	65	97	NO
78	RMC	M	72	78	NO
79	RT	M	49	59	NO
80	PI	M	43	93	NO
81	CC	F	51	100	YES
82	JG	F	50	96	NO
83	WH	F	16	74	NO
84	JF	F	21	80	NO
85	IK	F	64	95	NO
86	CLT	F	21	63	NO
87	JB	F	50	100	NO
88	JF	M	69	100	YES
89	AR	F	55	99	YES
90	JF	F	52	100	YES
91	CG	F	83	100	NO
92	WK	F	32	99	NO
93	FH	F	43	76	NO
94	JI	M	78	98	NO
95	SP	F	48	100	NO
96	ML	F	46	100	NO
97	MMC	F	45	95	NO

98	KS	M	69	98	NO
99	NG	F	32	100	NO
100	SC	F	58	98	NO
101	NM	F	30	85	NO
102	PD	M	50	75	NO
103	JL	F	42	100	NO
104	GS	M	46	91	YES
105	JJ	M	31	84	YES
106	AR	F	21	100	YES
107	JL	F	28	88	YES
108	NC	F	22	84	YES
109	WJ	F	37	67	NO
110	MG	F	51	93	NO

*** Indicates consultation/interview was not used as data.**

Table 4 Treatment categories of patients interviewed from Dr 1 consultations.

*At the point of interview the decision had not yet been made to exclude children's consultations.

Table 4

Sex	Category	Description	Decision
F	Symptomatic	Asthma management	*
F	Referral	Change in mole/wart	Dermatology
M	Symptomatic	Viral Illness	Symptomatic relief
F	Asymptomatic	Hypertension	Medical review
F	Symptomatic	Pleuritic Pain	Symptomatic relief
F	Mental Health	Depression	Anti-depressants
M	Symptomatic	Diverticular Disease	Symptomatic relief
M	Symptomatic	Sporting Injury	Symptomatic relief

Table 5 Treatment categories of patients interviewed from Dr 2 consultations

Table 5

Sex	Category	Description	Decision
F	Prevention	HRT and Hypertension	Postpone treatment
F	Mental Health	Bereavement	Grief support
M	Referral	Haematuria	Urology Referral
F	Referral	Swelling/tumour	Oncology Referral

Table 6 Treatment categories of patients interviewed from Dr 3 consultations.

*It was found at interview this patient was suffering from confusion.

Table 6

Sex	Category	Description	Decision
F	Symptomatic	Chest Infection	Antibiotic treatment *
F	Prevention	HRT and Hypertension	Postpone treatment
F	Asymptomatic	Hypertension	Review
M	Asymptomatic	Hypertension	Review
F	Prevention	HRT	Review
M	Symptomatic	Haemmorhoids	No treatment
F	Symptomatic	Arteritis	Steroid reduction

Table 7 Treatment categories of patients interviewed from Dr 4 consultations.

Table 7

Sex	Category	Description	Decision
M	Asymptomatic	Hypertension	Medication increased
F	Referral	Hearing loss	Audiology
F	Referral	Chest pain/ blackouts	Cardiology

Table 8 Treatment categories of Patients interviewed from Dr 5 consultations.

* Interview was impossible as there were three young children playing in the same room.

Table 8

Sex	Category	Description	Decision
F	Mental Health	Depression/anxiety	Medication changed
F	Asymptomatic	Weight/orlistat	Support *
F	Prevention	HRT	Review
F	Symptomatic	Diverticular disease	Symptomatic relief
F	Symptomatic	Viral illness and cyst	Cyst removed
F	Mental Health	Depression/anxiety	Medication changed
F	Prevention	Continence	Referral

Table 9 Treatment categories of Patients interviewed from Dr 6 consultations.

Table 9

Sex	Category	Description	Decision
M	Referral	Eye infection	Opthomology
M	Symptomatic	Back pain	Symptomatic relief
F	Symptomatic	Viral illness/sore throat	Nasal spray
F	Referral	Acne	Dermatology
F	Asymptomatic	Pregnancy	Referral

* When interview was carried out the patient had a COMRADE score above the mean. After collecting data at this practice at a later date the mean for COMRADE had changed and this patient score fell below this.

Tables 4-8 show that 34 interviews were carried out and four interviews and their corresponding consultations were excluded as material for data. Table 10 presents the distribution of treatment categories selected as material for data.

Table 10 Treatment categories.

Categories of thirty consultations ultimately selected as material for data analysis.

Table 10

Prevention	Asymptomatic	Symptomatic	Referrals	Mental Health
5	5	9	7	4

Table 11 Demographic information for doctors

This table presents the age, sex and year of registration for each GP.

Table 11

GP	Sex	Registration	Date of Birth
Dr 1	Male	1997	130366
Dr 2	Male	1991	210363
Dr 3	Male	1995	301263
Dr 4	Male	1983	151258
Dr 5	Female	1982	270659
Dr 6	Female	Missing	060567

Materials

Patient Information Sheet

You are invited to take part in a research project believed to be of potential importance. However, before you decide whether or not you wish to participate it is necessary to be sure that you understand first of all why it is being done and secondly what it would involve if you agreed. You should read the following information carefully. Be sure to ask any questions you have and if you want, discuss it with others. Any further information you want now or at any time will be provided. You do not have to make an immediate decision.

The study background

It is believed that when patients are involved in the decisions made about their treatment they are more satisfied with the care they get from their doctor. Also patients who feel treatment decisions were shared are more likely to take medication as prescribed. The Chief Scientist Office has paid for this study to find out more about the way shared decisions between patients and their doctors are accomplished. It is necessary to talk to a number of patients with different conditions to get an idea about how decisions are made. Approximately 50 patients will be asked to take part in this research.

What the study entails

If you agree your doctor will tape-record the consultation. Afterwards, the researcher will give you a short questionnaire asking how satisfied you were with the decisions you and your doctor made. You may be asked to discuss the consultation in more detail. The researcher will be happy to interview in your home or another place of your choosing. This will take about an hour. The information you give will help health professionals understand more about the kind of things said and done when treatment decisions are negotiated. This information is important for training doctors with the skills needed for shared decision-making.

What are my rights?

Only the research team will have access to the information collected. No names will be associated with what you say (names will be changed). Your GP will not be told of anything you say. Please feel free to discuss the study with friends, relatives and/or your GP before deciding whether to take part. Participation is entirely voluntary. If you choose to take part **you are free to change your mind at anytime.** If you decline to take part or change your mind later it will not affect the treatment you receive from your doctor.

Ethical Approval

The Tayside Committee on Medical Research Ethics is responsible for scrutinising all proposals for medical research on humans in Tayside and has examined the proposal and raised no objections from an ethical point of view. Monitors from the committee may examine your research records to ensure the research has been carried out in an ethical way.

For more information, please contact: Maggie Robertson
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Project Summary

Scientific Background
Shared decision-making can be seen as the joint involvement of health professionals and patients both in the process of clinical decision-making and in the ownership of the decision made (Elwyn et al, 1999). It is hoped that increasing a patient's involvement will improve his/her commitment to therapy, hence improving outcomes as well as patient satisfaction (Stewart, 1995).

Preliminary literature searches of Medline and Psyclit have produced a large volume of papers on the topic of shared decision-making. It is clear that patients' agendas are complex, multifarious, and often are at odds with those of the doctor and although there has been considerable effort in developing a shared approach to decision-making there is still a considerable need to define and refine the process (Coulter *et al.*, 1999; Entwistle *et al.*, 1998; Towle and Godolphin, 1999).

It appears that previous studies on shared decision-making have failed to take into consideration patients' own understandings of what might constitute important factors in this process. It is likely, therefore, that there are aspects of shared decision-making which patients consider important that have not been taken into account.

Justification for proposed study
By studying the clinical encounter and exploring patient's views it will be possible to 1) determine whether or not the process of shared decision-making succeeded or failed; 2) provide a detailed understanding of what constitutes shared decision-making from the patient's perspective; 3) illuminate the ways in which shared decisions can be accomplished in the practice setting and 4) suggest the specific skills required for the process by both the doctor and the patient.

Aims:
The aim of the proposed study is to identify and describe the discursive strategies used by GPs and their patients to achieve shared decisions in the primary care setting by 1) assessing patient satisfaction with his/her involvement in the clinical decision-making process and 2) selecting examples of best practice from the patient's perspective based on the above.

Sample and recruitment criteria
A minimum of five GPs with either a special interest or training in patient-centred medicine/shared decision-making will be recruited. Patients will be identified and recruited by GP's practicing in Tayside. Inclusion/exclusion will be based on the GP's own knowledge of his/her patients. In order to reduce bias with patient recruitment, a sample will be identified randomly from the eligible practices. Five different types of consultations will be audiotaped by GP's and those deemed by patients to constitute best practice will be selected for analysis.

Sample size
Fifty 'best practice' consultations are required to ensure that the study covers a wide range of patients thus ensuring that the findings are not specific to one particular type of consultation or social class for example.

What the study entails
The patient's own GP will provide him/her with an information sheet and secure permission to record the consultation. The researcher will approach patients immediately after the consultation has taken place and asked to complete a questionnaire. Semi-structured interviews will be conducted with those patients satisfied with their consultation.

Patients will be interviewed in depth for around 1 hour in their own homes. The purpose of the interview is to discuss in more detail their role in the decisions made during the consultation with the tape of the consultation being played back to patients during the interview. All interviews will be carried out by the researcher and recorded. Both consultations and interviews will be transcribed verbatim.

Analysis
After anonymising the transcripts repeated readings by researcher and colleagues from a range of disciplines will identify key themes. Next a discursive analysis will reveal a detailed description of the approaches used by GPs during consultations in which patients' considered shared decisions had been accomplished.

Criteria for withdrawal
Subjects may withdraw at anytime even after interviews have been completed.

Letter of invitation

(GP name)
(Address)
(Date)

(Patient name)
(Patient address)

Dear (patient name),

I believe you have made an appointment to see me at the health centre sometime in the next few days and I write to ask if you would be willing to take part in some health service research which is being conducted by Maggie Robertson, a researcher from the Tayside Centre for General Practice at the University of Dundee.

The purpose of the study is to provide information about how doctors and patients participate in decision-making. I would be grateful if you could spare some time to help with this research but participation is entirely voluntary.

If you agree to take part your consultation will be tape-recorded and you will be asked to complete a short questionnaire after the consultation is over. Some patients will be selected for later interview by the researcher. She will be interviewing people at a time and place convenient to them, including evenings and weekends. All participants in the study will remain anonymous and information collected will be confidential. I have enclosed full details of the study and what would be required from you if you agree to participate.

You will be asked for your decision on whether or not you wish to take part in this study when you attend for your appointment. If you agree at this time then I will go ahead and tape-record the consultation for the researcher. If you do not wish to participate no recording will be made. Should you wish any more information about the study you can contact the researcher directly at the address on the patient information sheet.

Yours sincerely, (GP name)

Interview Information Schedule

Thank you for agreeing to be interviewed today. As you know from the information sheet you were sent the purpose of the interview is to hear about patients' views on how decisions are made when people go to see their doctor. This study wants to look at patient involvement during the consultation and the communication between doctors and patients.

I am particularly interested in your involvement in the decision making process and how the choice(s) was/were made to (prescribe) (refer on to a specialist) (postpone) the decision about treatment (or no treatment).

Before we begin I want to remind you that you are free to change your mind or stop at anytime without having to give any reason and without this affecting the care you get from your doctor. Your doctor will not be told of anything you say and the information you give will only be used for the purposes of this study. Both your name and the doctors' will be changed to ensure anonymity. Have you any questions? Are you happy to continue?

First, we will talk a little about your visit to the doctor then, to help refresh your memory, I will play the tape recording of your consultation back. Afterwards, I do have some particular questions to ask but I want you to talk quite freely about how you see things. There are no right or wrong answers. Hearing about your opinions is what is important.
Do you have any questions?

Introduction

Sometimes decisions are not always made clear so the first thing I want to find out about is the reason you went to the Dr and whether or not you think a decision was made on this occasion On the questionnaire you filled in you said that the decisions made were shared between you and your doctor.
Can you tell me what it was about this consultation that made you feel this was the case?

- Your overall impression

Research has shown that there are particular steps involved when treatment decisions are made. I would like to ask you some questions with these steps in mind. Please say if you are not sure what I mean.

Before we listen to the tape is there anything more you would like to say?

Listen to tape

Interactive- I've already listened and I am interested in ... ...
I notice by your face ... ...
You looked to me like this was ... ...

Reason for seeing the doctor
1.

a. Expectations/ pt's understanding
b. Decision(s) reached
c. Agreement that 'no change was a decision.

2. Involvement/Role

People have different ideas about the part they play or want to play in deciding what should be done when they see the doctor.

d. In what ways did you feel involved
e. Who do you think was more involved – you or the Dr
f. What would you have preferred instead
g. What role suits you best in this situation

3. Exploration of ideas, fears and expectations

At times patients have different understandings and views about their condition or the treatment than the doctor does. Was this the case for you?

a. Do you think the doctor understands this
b. How do you feel about the treatment
c. Do you think the Dr understands your concerns

4. Options

Feeling you have a choice or a say in your own care is important for some people, others are happy for the Dr to choose. What do you think in this situation?

d. Do you think you were given a choice about treatments
e. How do you feel about having a choice in this way
f. What did you base your choice on
g. Do you feel you were given enough information to make the choice
h. Did you think you had enough time to decide
i. Was there anything important to you that wasn't mentioned/discussed
j. Was there any difference between what you thought would be best for you and what the Dr thought
k. How much were you influenced by what you thought the Dr might have wanted for you

5. Satisfaction with decision made and role taken

It is very important that patients are happy with the decisions taken about their treatment/care. Sometimes people agree to take a particular medicine or follow advice when they see the doctor but often change their minds later. This can affect their condition and also affect their relationship with their doctor. What do you think can be done to prevent this?

a. How satisfied were you with decision to -----
b. How satisfied were you about taking an active/more passive role in reaching the decision
c. What else not mentioned might have made you even more satisfied

I think we have just about covered everything. Is there anything else you would like to add before we finish?

Thank you for agreeing to participate in this study. Would you have any objections if I needed to contact you at a later to clarify anything?

Study Consent Form

Tayside Ethics Consent Form

(The patient should complete this form himself/herself)
PLEASE CROSS OUT AS NECESSARY

Have you read the Patient Information Sheet? **YES/NO**

Have you had an opportunity to ask questions and discuss this study? **YES/NO**

Have you received satisfactory answers to all of your questions? **YES/NO**

Have you received enough information about the study? **YES/NO**

Who have you spoken to? Dr./Mr./Mrs. .....

Do you understand that participation is entirely voluntary? **YES/NO**

Do you understand that you are free to withdraw from the study:

* at any time?
* without having to give a reason for withdrawing?
* without this affecting your future medical care? **YES/NO**

Do you agree to take part in this study?

YES/NO

Patient's Signature ..... Date .....

Patient's name in block letters .....

Telephone number where patient can be contacted:

..... **(Home)** ..... **(Work)**

Doctor's signature ..... Date
.....

Consultation recording – patient consent form

Place ... ... Date: ... .../... .../... .....

Patient's Name ... ...

We would like to record some consultations between doctors and patients. This is so we can study the ways in which doctors and patients reach a shared decision about treatment. This information is important for training doctors in the skills needed for shared decision-making.

If you agree your doctor will tape-record the consultation. Afterwards, the researcher will give you a short questionnaire asking how satisfied you were with the decisions you and your doctor made. If you agree, you may be asked to discuss the consultation in more detail. The researcher, Maggie Robertson will be happy to interview in your home or another place of your choosing. This will take around an hour.

Maggie Robertson has been given permission by Tayside Ethics Committee to carry out this study. Only the research team will have access to the information collected. Names will be changed and the tape will be kept in a locked cabinet. You do not have to agree to your consultation with the doctor being recorded and you can change your mind at any time.

TO BE COMPLETED BY PATIENT

I have read and understood the information and given my permission for my consultation to be audio-taped.

Signature of patient **BEFORE** consultation

... ... Date ... .../... .../... ...

After seeing the doctor I am still willing / no longer wish my consultation be used for the above purposes (delete as appropriate)

Signature of patient **AFTER** consultation

... ... Date ... .../... .../... ...

If you are happy to be interviewed by the researcher at a later date please provide your telephone number and she will call you soon to arrange this.

Patient's Telephone Number ... ...

Transcription Notation

- The notation used is derived from Potter and Wetherell (1992).
- Pseudonyms were used in place of all names except the researcher's name.
- Punctuation is used to facilitate readability.
- Brackets identifying words or sounds made by the other speaker.
- Noticeable pauses are indicated by a full stop in brackets (.).
- Timing of pause lengths was considered to contribute to this analysis and as data had been recorded on minidisk the lengths of pauses were immediately available from the raw audio data and included in transcription.
- Interruption by another speaker is indicated by a colon ':'thus marking a restrained utterance.
- Overlapping talk is marked with ( )
- Where talk is omitted in the middle of an extract this is reported.

Consultations

1. D6ARF

Dr: Hi, come in, have a seat. Did you have a chance to think about the study?
Pt: Yeah.
Dr: Is that okay?
Pt: That's fine, no problem.
Dr: Now what can I do for you?
Pt: Em, loads of things (laughing) hopefully.
Dr: Okay.
Pt: First of all, em, could you please refer me to dermatology (Mhmm) for my face? It looks as though it's okay just now actually. Ha. Ha.
Dr: Yes. What problems are you having with your, it?
Pt: Well since I was eleven, I think, about eleven when I first started, just normal (Yeah) teenage skin and they says "oh it's just a phase and you'll grow out of it" and (You're sick of it) I'm twenty one and although, yeah, really. Like really, em, it's, it's like a main, well it seems to the main thing that. The only thing I ever worry about or that bothers me or that. I don't know, it's just always an issue.
Dr: Do you feel as if you've got any scars?
Pt: Yeah, I have loads (Yeah) and the sort of big angry spots I don't get as many of but my skin's just, em just, it's just horrible (Mhmm) like it's really awful.
Dr: What have you tried for it in the past?
Pt: Everything and every time I've come to the doctors they just say.
Dr: You've been on Dianet? (Yeah)You've been on antibiotics haven't you?
Pt: I've had creams and everything.
Dr: Have you ever been on Dianet? Sorry not Dianet. Have you ever been on antibiotics for a long period of time? I'm talking like six months, a year, that kind of thing.
Pt: I think about six months I took something.
Dr: Mhmm. Em right.
Pt: But to be honest there's been that many things I've tried it's (Yeah) and every time it's like "just try this again", "just try this one last time".
Dr: Do you know what they would offer you up at dermatology?
Pt: No.
Dr: The em, the main thing that they can do that we can't is offer Roaccutane. It's a very strong em tablet, basically that you take for three months.
Pt: Mhmm.
Dr: Em, you need to attend regularly and get regular blood pressure blood tests if you're on it because it can cause reversible liver damage. So in other words they need to keep an eye on your liver tests (Mhmm) because if they start to go wrong they need to stop the tablets immediately (Mhmm) and go back to normal. But obviously if they weren't measuring them if they didn't know (yeah) what was happening (Yes) you know it could get badly damaged before anybody would notice. So it is reversible as long as you stop the tablets you're fine but it is very strong treatment Roaccutane. Not only does it cause your skin to dry up and the spots to dry up but often it causes your mouth and your nose

and everything to get very, very dry (Mhmm). Most people it clears their skin and they either have no spots afterwards or it's much, much better than it was. The odd person, you know, it does come back (Yeah). But the vast majority of people it is, it works really well for. But it does mean that you go through intensive, you know, treatment. It's very important that you don't become pregnant on it because the Roaccutane can damage the baby (Mhmm). Em, as I say it's a lot of tests, it's a lot of monitoring, a lot of back and forward getting blood tests and things but the idea is for the vast majority of people they get a good result. They either use Roaccutane if your skin is very, very bad. You know, you see some people with horrendous skin (Mhmm) or they're now more sympathetic to people saying that 'I've had this since I was a young teenager, I'm now, I've had it for so many years, I'm sick of it and I want it treated'. So they are becoming more sympathetic to just use it for people.

Pt: Mhmm. It's not just my face either, its, there's my back.

Dr: Your back and your front.

Pt: Here as well so.

Dr: So yeah, er I mean, I can't guarantee that they would offer to you but that's the only thing that they can really offer that we really can't offer and I think there's a chance, a good chance, that they would offer it to you (Mhmm). But there's not a huge amount of point in going if you're absolutely certain that you wouldn't say yes to it. If you think you might say yes or you know you might say no then that's fine 'cos it's fair enough to change your mind but if you think under no circumstances would you take it then there's not much point in going.

Pt: No, I'm at the stage now I'd just try anything.

Dr: Okay. There's quite a long waiting list for dermatology so you're talking a few months before you'll be seen.

Pt: Yeah. Mhmm.

Dr: But it's no trouble to (Yeah) send you up

Pt: Yeah. That's, I assumed that anyway.

Dr: Yeah. Is that okay? Is there anything you wanted to ask about that?

Pt: No, not really.

Dr: No.

Pt: Its, It's at the stage now where anything will do. I'll do anything (That's right) I'll wait as long as it takes as long as at the end there's a chance and like you say quite a good chance.

Dr: There is a good chance. I mean, but as I say, that it should work. So I can do the letter to dermatology? Did you say there was another thing you wanted to ask me?

Pt: Yeah. I've never had a nose bleed in my whole life.

Dr: Aha.

Pt: And on Monday I had one and it wasn't just like "oh my nose is bleeding. It was like pouring with blood (Mhmm). Em, and then again on Tuesday, again on Wednesday and again this morning.

Dr: Okay.

Pt: Monday it was about dinnertime. Tuesday it was, I was up at half six so it was about half seven. The same yesterday, and today it was actually when I was in my bed.

Dr: Right.

Pt: And the reason it woke me up was 'cos I was choking on it.

Dr: Yeah.

Pt: It's like really pouring.
Dr: Okay. No bruising or anything anywhere else?
Pt: No. It's just.
Dr: Let's have a look. Is it both sides?
Pt: No just the, er, right hand side.
Dr: Right. Have you had a cold or anything?
Pt: No. And I like, and everyone's saying have you changed this or have you changed that? And I haven't.
Dr: Okay. I think when you get one you often get another one because you can imagine em there's a bit of broken skin inside your nose if you like and so it's quite common once it's happened once it's not fully healed up and it can happen a few times until it heals (Mhmm). But em there's not usually any great cause for nose bleeds.
Pt: No. That's okay.
Dr: If it's still continuing you can get your nose cauterised and things but.
Pt: No, it's just the only experience.
Dr: The fact that it's happened once and then it's happened several days in a row after that is quite a common experience as I say.
Pt: Right. That's okay. It's just the only experience I've got, my dad had a haemorrhage.
Dr: Oh right.
Pt: That's the only thing in my family that's been (That's right) and I know, as soon as I got one, Panic! Ha, Ha.
Dr: Ha, I know.
Pt: Em, but that's fine.
Dr: That's fine.
Pt: Em, I thought maybe my blood was too thin cos I cut myself two weeks ago and it won't heal. I've got a cut here and it won't heal.
Dr: Yeah. But you've had no bruising or anything?
Pt: I don't really bruise anyway. No.
Dr: I would say it's most likely just one of these things.
Pt: That's fine then. Just the thing will do. That's great. That was it.
Dr: Okay. So, if you go and see Maggie (through) right across (Yeah) and I'll do a letter.
Pt: Okay. Thanks very much. Bye.
Dr: Okay then. Bye just now.

2. D5ARF

Dr: Good. Right. So what can I do for you?
Pt: Em, I've got a hearing problem.
Dr: Right.
Pt: So what I'm here for is to find out if it's a real hearing problem or whether it's wax or fluid in the ear.
Dr: Okay. How long has this been a problem?
Pt: Eh, maybe just on the decrease over the last year or two but recently em a bit more pronounced.
Dr: Okay, what sort of things do you find difficult hearing?
Pt: Well if people are speaking and there's music on for instance at work I'm not hearing them properly.
Dr: Right.
Pt: And we're not hearing the phone my husband and I at night either (Either). So we're both on a decline. Em, basically, if there's background noise like people are in the front of the car and I'm in the back I'm not hearing them.
Dr: Right. Okay. And is it both ears do you think are equally affected?
Pt: Well I tested both. I think probably less on the right. I've got less hearing on the right.
Dr: Right. And you feel this has been over the past year or so?
Pt: Yes. Aha. I think I actually asked Dr Smith to test my hearing maybe two or three years ago (Right) and he thought it was down slightly. But see how it went (Right). Maybe some time ago.
Dr: Yeah. Did he arrange for a hearing test?
Pt: No (Or just) no, no. We were just going to see how things went.
Dr: I often find actually trying to test somebody's hearing just by speaking it different, doesn't really, I usually:
Pt: He used a tuning fork.
Dr: Yeah. That looks after different types of (Does it?) different um wavelengths of hearing. So you actually, you probably need four or five different tuning forks to actually assess completely. But I think if yeah what we'll do is we'll look in your ears (Right, and see if) see if there's anything, wax or anything and then decide. Is that the stage though if you're ears are clear you think you're getting a formal hearing test?
Pt: I think so, yes. I think so. I, I'm alright on the telephone, it's just you know when people are speaking quietly and it's obviously important that I hear people.
Dr: Yeah. Okay, let's have a look. There's some wax there but it's not, probably I wouldn't have thought enough to and there's none at all in this side. Are you able to pop your ears? You know that sensation where you (No, not really).Not really.
Pt: I don't know how to do that.
Dr: I'll test your hearing again with this. Put it to the back of your ear and then round the front and just tell me what you think the louder noise is. Okay.
Pt: Right.
Dr: So that or that.
Pt: Front.
Dr: Front.
Pt: Mhmm.
Dr: Okay. Same again? Back or front?

Pt: Again in the front.
Dr: Okay. And I'll put this to the centre of your forehead and just tell me if you, if the sound seems to be coming from the centre or from either side. Okay?
Pt: I'd say that's central.
Dr: Right. That's as you'd expect. That's normal.
Pt: Right.
Dr: Hearing at work not so good. You obviously hear better through air than conducting it through the bone unless and it's more sort of small children blocked ears that struggle with those tests.
Pt: Okay.
Dr: Right, um I would have thought the only way really to know would be to do a hearing test. Um now I can refer to up to PRI to the Audiology Clinic (Yeah) and I'm happy to do that and the only reason I'm not saying this is what I'll do is because I know the waiting list is a long, long time so if you don't mind that's fine.
Pt: I don't really mind. And also we can arrange these things privately if you wanted to.
Dr: Well that's what I was going to say because the audiologists have actually commented to us that I think a private hearing test costs something like £6.
Pt: Yes. Well I mean if you think that's the direction to go now I'd probably arrange that myself rather than elongate a health, a national health waiting list.
Dr: Yeah.
Pt: I'm quite happy to do that.
Dr: Right. I'm not sure if you can actually be seen, I don't know if the NHS does a sort of a private test as well if you know what I mean (Mhmm) because I certainly know the audiologist told me that, 0r she wrote to us saying that you could get it done quickly if you went privately (Right) and I think it's with them so I think sound a bit weird but em.
Pt: That's alright. There are always two sectors to these things probably.
Dr: Yeah. What I'll do is I'll do a referral up to the Audiology department and I'll say you're happy you know (Yeah) to be seen privately if there's a small charge involved. And get you're tests and decide what's what. It's probably not at the stage where they would really be much they can do because sad to say most often what they can do is give you a hearing aid. But it's important to figure out if it's just one side because (Yes) one sided hearing loss is slightly different than just a natural kind of (Right) ageing of your hearing. But if there was any concerns then you can be referred on.
Pt: That's great.
Dr So will we do that?
Pt: And so I'll hear from someone (Yes) in the near future.
Dr: Yeah. Indeed. I'll do that.
Pt: That's great.
Dr: Okay.

3. D5JFM

Dr: So how are you doing?
Pt: Alright.
Dr: How was the trip?
Pt: Great.
Dr: Danced your socks off over there, whatever the phrase is.
Pt: Yeah, danced. It was heavy though, marble floor.
Dr: Right.
Pt: Oh and they had the heating on. Of course it was cool. The floor was sticky with the heat (Right) and we put the heating off and the floor was alright but the ladies had to put on cardigans and they didnae like that. I mean the dress, the nice dresses, so you couldnae win.
Dr: And the hernia stood up?
Pt: I had nae problems with the hernia.
Dr: That's right. And you said your blood pressure was fine when you were up there at the day clinic.
Pt: Yes. And the wife said the doctor will no find nothing wrong with your blood pressure. Yesterday she says, "He won't find nothing wrong with your blood pressure tomorrow" (Right). She was being cheeky because one or two things at her where I would have been gnashing ma teeth.
Dr: Oh right. You were relaxed.
Pt: Yeah. Oh.
Dr: Right. Let's see what it is then. Turn the old machine on (Blood pressure recording). Similar. I mean the second value the diastolic's good again at eighty seven but the systolic, the first value, is up again at a hundred and ninety-five. Right, em when's the hernia op? Do you know yet?
Pt: The what?
Dr: The hernia operation?
Pt: Oh no, no. Nae problems with that.
Dr: Right. Okay.
Dr: It must have been a cancellation or something they put me in for you know.
Dr: Right. Right. I mean certainly looking at things for the last you know six months or so it's, its, this systolic value's still been high as the first test and, em, I think if your other risks are good, I mean you don't smoke, your cholesterol's good um I just wonder if we should be trying a wee bit harder to lower the first value. You're not getting any side-effects from the tablets you're on?
Pt: No. I would have been telling you right away.
Dr: That's right cos you had problems with the Amlodipine didn't you? But the new one's (The new one's) agreeing with you. What would you think about us increasing the dose a wee bit of that and try and get.
Pt: Aye. Yeah. I just thought I was doing alright.
Dr: Well you are and you're doing well. The thing about it, I could show you some, I've got a computer chart I could show you the difference lowering your blood pressure a wee bit would make if you want to. Do you want to have a look at this?
Pt: Well, if you've got the time have you?
Dr: Aye. I like my wee strange computer things. This is to try and anticipate somebody's risk of having a heart attack or a stroke. Okay?

Pt: Aha.
Dr: I don't know if I've shown you this before. What we do is we put all your details in here. So you're what seven:
Pt: Seventy.
Dr: Sixt: You're sixty nine.
Pt: Oh well I'll be seventy in June so.
Dr: Oh no we don't want to load your risk.
Pt: Oh but I'm fine.
Dr: This is the one that will change. I mean:
Pt: That's, that's:
Dr: One hundred and ninety-five which is a wee bit up. So your other blood pressure's good. You don't smoke. The last was good. Three point seven three is excellent. HDL is one point zero four. Diabetes and ECG was fine wasn't it? Yeah. Okay. So, there's your risks. I don't know if you can see them there. Most of them are related to your age unfortunately but you, based on your systolic which is the first value, you've got you've got a one in four chance of having a heart attack in the next ten year.
Pt: That's good gamble.
Dr: Well, I mean you, you'll be eighty at the time so it sounds bad but if, look, we manage to get your blood (patient laughter) pressure down) say to one five o' the risk drops from, it drops about five percent but the other risks don't really change that much. So what we'll need to decide is really you know (yeah) I think we should probably increase the dose and see how you get on, but if you get any side-effects from it then we'll just cut back.
Pt: I dinnae foresee that because there are nae problems at all with it you know so:
Dr: Yeah. Let me just double-check the dose we can go up to. I think we're on quite a low dose to start with.
Pt: Should be round about a quarter or something like that.
Dr: Yeah I think you can go up to three sixty milligrams. There are just so many different preparations it's difficult to keep a track on all of them. You can go up to two forty. The Exavilane doesn't. Right we'll go up to um one eighty okay and then we can go up to two forty if we need to. Okay?
Pt: Yes.
Dr: So we'll increase that by a thir: by a half the dose and give you a hundred and eighties. Are you okay for your other medications?
Pt: I've enough for four weeks.
Dr: Right. Sorry to keep dragging you back but we may as well see you in four weeks.
Pt: No problem as I'm doing nothing else.
Dr: Hee, hee. Okay. So I'll give you the new dose of the Adizane which is just up a wee bit and we'll see if that makes a difference and we'll see you again in four.
Pt: You're going to give me a dose for four weeks?
Dr: Yeah.
Pt: Right. I'm away on holiday for one week. From the 18th March so how does that fit in?
Dr: Well 28th of March cos you know it's a four week month.
Pt: That's okay then.
Dr: What time do you want to come in? About nine?
Pt: Same time.
Dr: About ten past nine?

Pt: Yeah.
Dr: And that's you got, then you don't need to, you can ignore the receptionist as you're going out if you want to.
Pt: Yeah I don't (unclear speech)
Dr: That's quite a good idea because you've had enough sitting.
Pt: What do they get to do? What do they do?
Dr: Well people come to the desk.
Pt: Aye that's another, that phone or this one and she says to the one next to her (unclear speech). She's holding the thing like that so as the two of them could hear whatever it was and I thought 'what's a' that fae those shits"?
Dr: Ha, ha. Hmm. We've moved the phone back, I don't know if you've seen that. The computers are now back behind that glass partition 'cos what was happening was when people were coming in and the receptionists were sitting at their desk and somebody was talking to them and they had the earphones on them and you know you don't really see them and I think the patients thought they were being ignored but the receptionist was actually on the phone. So now the phones are back behind the desks.
Pt: Aye, I see you've got them back on the desk.
Dr: Yeah. So that now if you come to the desk and somebody's there they should be able to speak to you.
Pt: Well the problem is (laughing) Trouble is there was a woman there when I came in this morning, there was a man in front of me and then there was myself and this woman was wanting to make an appointment.
Dr: Aha.
Pt: She was going through all the days and there was this and that.
Dr: There are no appointments.
Pt: And eh. Yeah, but this guy was standing and I was standing waiting and I says well I'm alright cause if I see you see you coming along the corridor I can just, you know and just (That's right, yeah) but, but it, anyway it meant there was a queue formed because there was only one receptionist.
Dr: Yeah I know. We need more staff. We need more staff and we're actually understaffed in terms of receptionists compared to a lot of the other practices in Tayside.
Pt: Are you?
Dr: Yes.
Pt: There seems enough of them there.
Dr: Well, I know but it just shows you doesn't it.
Pt: However, there are a lot of doctors. What they don't realise is how many doctors are actually working.
Dr: And that's the difference because the number of doctors have increased in the practice over the years but the number of staff haven't.
Pt: Yeah.
Dr: So when I started in general practice they used to talk about a ratio two members of staff to one doctor but that's nowhere near like that now. So (No) So hopefully that's going to change in the next year or two.
Pt: Yeah. It's changing altogether isn't it.
Dr: And if the doctors stopped taking holidays it would be fine as well.
Pt: So where are you going on holiday?
Dr: Golfing in Spain on Sunday.

Pt: Golfing in Spain. Well we was er, took us on a tour round the golf course, two golf courses in Majorca. Gees what a place this was. Ye need a buggy to go round there.
Dr: Oh yeah. Oh yeah.
Pt: I've seen one or two in Spain er moving on the trolley and we were going up to where the oranges grow and you go away down there near Gibralta and all the golf courses.
Dr: Mhmm. Aye that's where we're golfing. Wonderful.
Pt: A golfer's paradise.
Dr: That's right.
Pt: There was a few friends of mine that go up the Ex-service club and they go to Spain every year and golf like, you know. They get away fae the wives. Are you getting away fae the wife are ye?
Dr: Yeah but that's not the main reason for going.
Pt: Oh come on don't give me that.
Dr: Remember we're being taped so I have to be honest.
Pt: Ha Ha Ha! You're not taped all the time?
Dr: No.
Pt: No. Only taped on the course.
Dr: That's right.
Pt: It's a thrill as long as you don't miss.
Dr: No it will be good.
Pt: You'll enjoy yourself. That's great. What date did we get?
Dr: 28th of March.
Pt: Oh, I've got a card.
Dr: Four weeks today. Same time.
Pt: Jings. Ye cannae dae nothing for my mental attitude that's the thing can ye?
Dr: No you've always been like this. Okay.
Pt: Okay. There's something niggling in my mind and I don't know what it is.
Dr: What?
Pt: Don't know. Once you're away ye can remember.
Dr: Oh well you can tell me about it next month.
Pt: Okay have a great time. Thanks doctor. See you.

4. D2CCF

Dr: In you come.
Pt: Sorry to keep you and you're running late as well.
Dr: It's okay. Right. Are you okay with the tape?
Pt: Yes, aha.
Dr: So how are you getting on?
Pt: Okay I think. I think.
Dr: Are you just in for a general check as we said?
Pt: Yes.
Dr: Because we spoke to you about it all on the phone and things.
Pt: That's right.
Dr: So you are taking Methotrexate three tablets once a week?
Pt: Correct.
Dr: And your folic acid three days later?
Pt: Yeah.
Dr: You have only had two lots of blood tests so far I think. First one was fine. I haven't seen the second done. It was only just done yesterday so we haven't got it through but the other one was obviously fine.
Pt: That's good.
Dr: Em and you have increased your Diltiazam to two (Mhmm) each day? Okay.
Pt: And the Prednisilone?
Dr: Oh yes that's right. Yes. It's gone up. Yes. How are you getting on with that?
Pt: It's making me feel awfy knackered this time (Is it?) Ha, ha. Can I say knackered?
Dr: You were on twenty milligrams and they suggested:
Pt: It's maybe just with everything getting bumped on at the same time could it be?
Dr: Er, I mean it's, I think it probably is everything yeah. But I must admit I was looking, thinking about things after you were in and you went and two months does seem an awful long time at the high dose but I don't have the proper length, just the message left to em to see if we could discuss it. Em, I'm just seeing if any more letters came in just to check that that's exactly:
Pt: Oh I got one to show you here.
Dr: Twenty. So I mean, I think twenty milligrams in two months, Mhmm.
Pt: It is quite a lot eh?
Dr: It is. I:
Pt: I don't know if I was even:
Dr: That much before.
Pt: Yeah.
Dr: I, I would, let's cut. Let's, let's sort of go middle ground. Say a month and then we can start reducing it. (Mhmm) I think okay. Right that's fine. Yeah, that's just breathing tests. Yeah, because you started the Methotrexate but it doesn't matter that you have actually started it they just want to get a base line near the beginning (Right). So, em that's today.
Pt: Yep.
Dr: Yes. Fine. Just a breathing test. Just as a base line
Pt: With time for a, a bite of lunch in between
Dr: Yes I know. Okay. Can we check your blood pressure today and just see what it is doing? Other than that we were just seeing how you were doing really wasn't it and just making sure that things were working out okay with you.

Pt: I don't feel any dramatic difference I thought I would have (Mhmm) felt something happening.
Dr: And we'll need to check, I will need to make sure they write down that we need to check your E.S.R. again sometime. That hasn't been done the last couple of times. I will maybe put that in just to, that's grand. Okay. So you wont, you won't have been on, you have been two weeks, a week on the higher dose of steroids now?
Pt: Two weeks
Dr: Two weeks. Yeah. So I'd give it another two weeks and then we will start the reduction that we talked about. Do you remember what we said?
Pt: Down to nineteen is it? I don't think we went as far as fifteen ay no?
Dr: Well they are down at two point five milligrams. I will need to give you some two point five milligrams.
Pt: Oh yeah.
Dr: So you will be seventeen point five, em (Mhmm, Mhmm) in another two weeks. For a, they said two months so I think we should do it monthly though
Pt: Right.
Dr: Yeah it just seems an awfully long time to reduce it em so I think month.
Pt: So two weeks today I'll reduce it to seventeen point five.
Dr: To seventeen point five for a month.
Pt: Okay dokey.
Dr: A hundred and forty-two over eighty-four. How does that compare with the bottom one?
Pt: It's down. It was ninety. Something like that.
Dr: Yes it is a wee bitty better then. A hundred and forty-two.
Pt: Thank goodness for small mercies eh?
Dr: Okay. So just pan on as we are doing.
Pt: Aha.
Dr: I will need to give you some two point five milligram tablets.
Pt: Yes please. Twentieth March I'm in to see Dr Black.
Dr: Right.
Dr: Ok and are you all right for other tablets just now?
Pt: Yes thank you aye.
Dr: Okay. There we go. That's those.
Pt: Thank you.
Dr: Okay and just keep coming for your blood tests. When are you seeing him?
Pt: Twentieth March
Dr: Twentieth March. Okay. So maybe we should see you, assuming everything goes along fine, we should see you after that.
Pt: Okay. So you so you don't want to see me again?
Dr: I don't think, I don't think that we don't want to see you. It's only if we need to see you and I think unless there is a problem. You know what you are doing.
Pt: Yeah.
Dr: You are having your blood test and if anything was to come up with any of those we would obviously, you know.
Pt: Give me a ring?
Dr: Yeah but I think just carry on doing what you are doing and we will see you sort of March/April. If any problems before we'll see you.
Pt: Okay dokey. Right.
Dr: Okay. Right o' then.

Pt: Thanks again.
Dr: Bye just now.
Pt: Bye.

5. D2CB3F

Dr: I'll need to get you to sign it before you go as long as you're happy with it.
Pt: Thanks.
Dr: I have met you before but it's a wee while ago.
Pt: Yes. A wee while.
Dr: What can I do for you today?
Pt: I got a message on my prescription to come and see you. I also wanted to see you because I've been for an eye test and I don't know, they found something and they wanted me to go and see a specialist (Right) about it.
Dr: Is this the letter?
Pt: That's the letter.
DR: Ah right. This is the letter.
Pt: Yeah.
Dr: Can we do the, we'll do the HRT first.
Pt: Yes.
Dr: Is that all right? This is your usual check up for your HRT.
Pt: Yes.
DR: I'll leave this a second. And it's the Timolin?
Pt: Yes.
Dr: How are you getting on with it?
Pt: Well, fine. No side-effects.
Dr: No problems with it?
Pt: Fine, yes.
Dr: That's been how long now?
Pt: Quite a long time. Since before I came to Montrose.Yes.
Dr: Right. And remind me. Remind me, you went on to it because? Was it just because you went through the change or was it because of:?
Pt: Yes. It was the lady doctor in Broughty Ferry who recommended it.
Dr: Right.
Pt: It was quite good you know also (unclear speech)
Dr: And it's not because you had any surgery or anything?
Pt: No.
Dr: No. Okay. So you would be on it for five years now. 'Cos nineteen ninety-eight you came to Montrose so:
Pt: Oh definitely. Yes definitely.
Dr: And we talked last time about being on it longer term or some of the issues about being on it.
Pt: Mhmm.
Dr: Did we talk about the breasts?
Pt: Yeah you said:
Dr: Lumps and things.
Pt: Concerns like that.
Dr: Well a little bit concerned. I think it's the longer-term use that we're concerned about with the HRT.
Pt: Yeah.
Dr: The important thing is that you're looking after yourself. I mean do you keep a check on the breasts?
Pt: Yes. Yes.

Dr: And as far as mammograms go?
Pt: Yes I had one. I don't remember.You should have had the result back.
Dr: Was it here you had one done?
Pt: No.
Dr: No.
Pt: I think I went to one of the ones that go round.
Dr: Because they come here about every three years em and I'm not sure when you: would it have been while you were still in Stirling?
Pt: I have a feeling I was here.
Dr: Certainly the van has been here since 199? It was here.
Pt: The Tesco place at Stirling. Then I go down there so.
Dr: Usually get a little sticker that goes into the notes to say you attended and it was fine.
Pt: Maybe after a certain age.
Dr: How old are you now?
Pt: I'm sixty-seven now so I think after that.
Dr: It goes up to sixty-five.
Pt: I think up to sixty-five.
Dr: You can still go and have it done. You request it. A number you phone here in Dundee (Right). They still only recommend having it done every three years (Right). What I can't see is when you last had it done. I can't see when it was last done. I certainly can't see it was done here because we have a system where if you've had it done.
Pt: No. I certainly didn't come here.
Dr: Right and previously it would have been done:
Pt: It was one of the mobile units I went to.
Dr: Right and you think it was done at Stirling?
Pt: Yes, it was in Stirling definitely.
Dr: Let me see if there's anything in your notes because I don't know what the system is from it's a different health board and therefore I'm not quite sure what the system is for sending the information out. Did you get a note yourself saying it was fine?
Pt: Yes. Yes.
Dr: And was that a letter that you got. Can you remember?
Pt: I'm trying to remember.
Dr: Right. It might have been a while ago. Let's go back. It's just to make sure that you're in some system. X-ray, breast x-ray examination, that was nineteen ninety-two.
Pt: After that.
Dr: Breast examination. That's right enough so (yes)
You would be due one again, that was in Feb, January, nineteen ninety-nine so January two thousand, January two thousand and one would that be right. Nineteen ninety-nine, two thousand, two thousand and one. You'll be due one the beginning of next year?
Pt: Yes. Mhmm. Yes.
Dr: If you ask them at the desk, what they can do is em, because you're now in Tayside rather than in Central and it's a slightly different set up they can fit you in if you wish to continue having breast screening done every three years even though you are beyond the screening age but there's a number you need to phone in Dundee to arrange to go up and have it done at some point.

Pt: So you have to go to Dundee.
Dr: Unless we get sorted in here the next time they come but that's going to going to be another two years because they were here just last year if I remember rightly, they were here and did the breast screening. So you've just missed it (Mhmm). Now they might be able to tell you if there's a mobile one somewhere nearer.
Pt: Maybe in Perth or something?
Dr: They may be able to advise you of that. But there is a number. If you speak to them at the desk they may be able to give you a number to phone for the breast screening service to get you fitted in. To make sure you can still have it done every three years even though you're outwith the age range (Right). They rely on people making the effort rather than sending out reminders once you get beyond sixty five (That's alright) but I would recommend that you should still continue having your breast screening done if you continue on HRT (Mhmm) really because there is that increased risk just in case. The more you can do to look after yourself the better when it comes to that.
Pt: Right.
Dr: What are your thoughts about continuing with the HRT?
Pt: Well I'm quite happy to continue with it.
Dr: Right, okay.
Pt: If that's okay with you.
Dr: I'm happy to prescribe it. I think obviously on the understanding that there are those slightly increased risks (Yes). We always advise people on them. A lot of people decide just to take that risk and say "well, I'll keep an eye on myself. I'll go for my screening" and that's fine. Some people say "no I don't like the idea of that" and they stop it (Stop, yes) but it's, it's a personal choice (A balance isn't it?) and I obviously wouldn't sway either way. I would say it's up to yourself what you feel comfortable with.
Pt: Mhmm. Well if that's:
Dr: That's fine, okay. We'll give you some more. We'll check your blood pressure today. We haven't done that for a wee while. If you can slip your jacket off and we'll check that. And no bleeding or anything like that?
Pt: No.
Dr: Okay, fine. Pop your arm out for me. Just turn away for me. That's fine. A hundred and forty-two over seventy-six. So no worries there. That's fine. Okay, so that's fine. Em, okay doke. Let's have a wee look at this letter and see what the optician's saying about your eyes. Em. Right. And did they? I mean did they? They didn't mention, did they mention the pressures?
Pt: They mentioned the pressure. They em, they said that (The pressures were alright) last time I had gone they, they had been a little bit suspicious (Aha) and this time they thought that:
Dr: But did they think the pressures were up?
Pt: It was something to do with in behind my eye.
Dr: What they're saying is that when they look at the back of the eye they look at the bit where the nerve comes in at the back of the eye to supply the eye and they're suggesting that it normally looks quite flat but sometimes you can get it looking a bit hollowed, as if there's something pressing, like a bit of pressure in the eye. They're suggesting that perhaps it looks a little bit more pushed in than when you previously had it checked (Yeah). They also I think felt that your, your eye, there wasn't such good vision all round the right eye.
Pt: Yes that's right. One of, you know, one of the tests I found difficult just the test

Dr: Yes the light dot.
Pt: Light dots and oh, I can't:
Dr: It may just be that it was a difficult and it can be a hard test to do.
Pt: It's horrible.
Dr: Putting the two together they're concerned about the pressure in the eye but saying that the actual most important thing is measuring the pressure and the pressure is normal. But I would never go against their advice. I don't go against their advice and they're saying you need to see a specialist then that's fine. We get a referral from an optician we say fine, you need to get specialist assessment, it's not a problem. But it doesn't quite add up. It does need sorting out by the specialist so I would be happy to refer.
Pt: (unclear)
Dr: Oh I'd be happy to refer you.
Pt: Would you mind if I go privately?
Dr: No.
Pt: They said it would take about eight months.
Dr: Well it won't take that long. But certainly referring you privately wouldn't be a problem. And so I could refer you up to see one of the opticians in Perth and get them to see you privately.
Pt: Right.
Dr: Yeah. I can do that, so I'll keep hold of this referral to make a private Opthomology referral for you.
Pt: Right.
Dr: Okay, so I'll give you your Tribulone. Do you normally get three months at a time? And I'll authorise it for the year.
Pt: Right.
Dr: Then we'll see you back for a general check up in a year's time.
Pt: Right. Okay, that's fine, thank you very much.

6. D5CBF

Dr: Now.
Pt: So, originally when I made the appointment it was only to see you about my HRT (Mhmm) and to ask you a question about my eye. But I've taken his flu thing and I feel absolutely gubbed with it.
Dr: Okay. What do you want to deal with first?
Pt: Right, the HRT. It's due in about, I think it's a week or a few days or whatever.
Dr: You're on Premarin. Any problems with it?
Pt: No problems apart from the weight thing which,
God, I tried that, is it fat bustin' soup? It's okay.
I lost about five pounds.
Dr: It is difficult, people:
Pt: Oh it drives me bonkers.
Dr: People put on weight with the menopause anyway and it's really hard to control.
Pt: It gets me down a bit. My mum says "Well what happened to my slim little girl? Mum I'm not a little girl and I'll never be slim". You know. Anyway that doesn't matter. That's the least of my worries. And another thing I came to ask you, this mark on my eye. I just want your opinion about it. It started off a long time ago. It was a little pluke and it just seems to have grown.
Dr: Mhmm. It is. It's a little cyst isn't it? It is a little cyst.
Pt: Mhmm. I'm quite happy to leave well alone but I thought I'm going to ask.
Dr: I'm just wondering if we could maybe just put something in it and take it out, whether it would work? I probably would be able to do that actually now. Do you want to um get it done? I mean all I would do is just open that up and let, I mean it's a very superficial cystic thing (Right). If it comes back then obviously if you wanted it we could:
Pt: Well can I ask you a few things while you're doing it?
Dr: Okay. No problem.
Pt: Okay. Can I take my coat of because I'm boiled?
Dr: Please do. And leap up. I always like people lying down when I'm doing things to them.
Pt: I know this cold thing will need to just run it's course but I am meant to be working tonight and I don't really know whether to head in or not.
Dr: Tell me what your symptoms are and let's, lets take it from there.
Pt: I just feel absolutely er I've got a tissue with me,
just feel absolutely wabbit (Yeah) and I have like this funny shaky feeling. You know when you're nervous (Mhmm), just a funny, and the thing is I want to be, I want to be reasonably well cos David's going in next week for his op (Right). So you see, apparently they go: Do you want me to lie down? He goes in on Tuesday, op'ed on Wednesday and out on Thursday.
Dr: Gosh, they don't keep him long. And it is a big op.
Pt: Apparently four ver: two crushed vertebrae and two that they're not quite sure em what they're going to find when they go in. They're talking about removing a bit of bone. But I think they were quite surprised when they did the MRI scan (Gosh yeah) and I got, you know, how you get a fright cos you know how they tell you the truth.
Dr: Yeah. They don't mince their words.
Pt: About all the down, the negative side and I thought oh that's quite scary.
David's very positive which is grand but I'm quite scared. Does that sound silly?

Dr: No. It sounds quite realistic considering all the hassles that you've had before and what you've been through and:
Pt: You know, I mean I knew. Anything to do with so far down the lumbar region:
Dr: Are they just biopsying it or:
Pt: No they're doing a laminectomy.
Dr: They're doing a laminectomy?
Pt: Dissectomy and I think a decompression.
Dr: Right. Well it might not be related to his other problems that's he's had.
Pt: All I'm saying. No I don't think it is. I think they would have said that. No.
Dr: No.
Pt: No. They're taking this as a separate thing all together. You know they used to keep them in so blooming long.
Dr: That didn't do them any good in the long run.
Pt: No.
Dr: But yeah. I know. You'll be fine.
Pt: I'm taking carers leave cos I'm not trying, I'm not going to try and work and look after him cos he'll need care.
Dr: He'll need looked after. You need to close your eyes, okay?
Pt: Mhmm.
Dr: I haven't quite finished yet. This needs opened up a wee bit.
Pt: You see all that fluid above my eyes as well?
I don't know whether that's, that's: Sometimes I get that in the morning. So I don't know whether it's because I've got this cold thing or not.
Dr: Well, that's it gone.
PT: Oh good. Brilliant.
Dr: It might be, it might fill a little bit (yeah) but if it does I certainly wouldn't do any more than that. Anything on the face, that would be a down the road job. Okay? We'll get things sorted. We need to deal with your blood pressure and things as well. So tell me about this fluey thing as well. We kind of got side tracked there again.
Pt: I know. I don't know. I can't think what else to tell you. I just feel so absolutely washed out.
Dr: Sore throat? Sore ears?
Pt: Sort of. Er not so much down your throat, more like in your mouth.
Dr: Aha. In there? Muscles?
Pt: No I just. No I just I cannae say. Just washed out.
Dr: Just washed out.
Pt: And this funny horrible feeling in here. Like a panic thing. But just a horrible: And I had a long lie this morning cos which is what I do when I'm going on duty and I got up and I thought God I was going to conk out. And I've had the flu injection.
Dr: Well I don't know. Could it be an anxiety or panic?
Pt: No I don't think:
Dr: I mean that's a possibility. Have you felt hot and shivery with it?
Pt: Well, yeah. I feel hot.
Dr: You feel hot and shivery.
Pt: Cos I was sitting in that office waiting to go andsee the lady and I thought if I don't get up from this heater I'm going to just flake out. And I mean I don't feel, I keep good health as you know. I mean, just suddenly feel Yuk. Yuk like this.
Dr: It does sound a bit virally doesn't it?

Pt: Yeah, yeah.
Dr: I guess it will come to a head and get worse or it will go away which doesn't really help you much but it does sound as if it is a virally thing and something'll happen. It will either get worse or get better. Either in the throat or it could be the start of a tummy bug or something like that. But obviously, if things don't settle then shout. Let's do your blood pressure.
Pt: Take this off?
Dr: Doesn't matter. I'm not fussy at this time of night.
Pt: Have you had a long, long day?
Dr: Just one of these things (phone rings).
Dr: Hold on. Hi there. Yeah, I have. That's okay.
He always nags me. Bye. My husband's nagging me as well now. It's terrible.
Pt: Oh dear, what a shame.
Dr: There we go. How long have you been on the
Premarin now?
Pt: Eh is it about eighteen months?
Dr: Must be about that. Blood pressure's perfect.
Pt: Is that the, is that the low dose I'm on?
Dr: Yeah. Yeah. Sixty-two point five milligrams. It's obviously agreeing with you.
Pt: Oh it agrees with me fine, yeah. I actually think it's better than the other pill cos you don't have that peak and then a low.
Dr: Yeah. No problem.
Pt: Good.
Dr: So let's just keep doing what we're doing then. Any problems, you know this sort of flu thing gets worse or whatever and you're having problems give us a shout.
Pt: Do you think I should go in tonight or:
Dr: I would probably: How do you feel? Where are you working?
Pt: South Park.
Dr: South Park.
Pt: Hell of a busy ward, not that I'm trying to cope it but:
Dr: Yeah. If you're not feeling right you're not feeling right at the end of the day. I'm sure they would find somebody if you were:
Pt: There's, there's loads on. I would have phoned really earlier if I'd thought but:
Okay, thanks for listening to my moans on a busy day.
Dr: That's okay. No problem. Bye now.
Pt: Bye.

7. D1DLM

Dr: Come in. Hi, Mr Smith. Temporarily staying up here are you?
Pt: Hi. I am, yeah. I wanna be in the study.
Dr: That's fine. Is that okay to join our little study we're doing? Yeah?
Dr: What brings you to Crieff?
Pt: I em, I'm working for Guide Dogs
Dr: Right.
Pt: I'm up here until October.
Dr: Only until October.
Pt: Yeah and then I go back down South.
Dr: Fine. Is this a university job or holiday or:
Pt: No. Er well I'm doing a course with them (Right). For them.
Dr: Right.
Pt: It's just like a six month placement (placement) really (Ah right), just to be up here.
Dr: Okay how can we help you?
Pt: Well my throat (Right). Ha. It started er I think last week and I just sort: and er I mean I smoke and I'd been having a few late nights and I just thought well it was down to that (Yeah)but especially (Right) this wee: well yesterday and today. It was really painful actually on Saturday round here and its spreading.
Dr: Right and:
Pt: Down there (Down there) erm, I don't think it's related but, but everywhere has their stakes whatever but a colleague of mine I've been working with she's, was off for a couple of days(Right) with the same sort of thing (Okay) but because I go outworking with people I just need to make sure it not (Yeah) too contagious
Dr: Quite, okay erm:
Pt: Er, I mean the voice isn't too bad today but it keeps coming and going.
Dr: Right okay. Mhmm. Em, I'll have a look in the throat just to see, you know, tonsils (Right), slightly swollen. Have you been taking anything to help?
Pt: Em I take medication anyway which is down there (Right) that's for something (Yeah) completely different. I bought some cough linctus from (Right) Boots.
Dr: Nothing to help the pain? Paracetamol, Aspirin gargles?
Pt: No, no.
Dr: There might be something we could, you know, add in. Lets have a look and see what there is to see. Open wide and say Aah (Aah). A bit louder (Aah). Stick out your tongue a bit. Yep. That's fine and Aah (Aah). Yep.
Pt: Sorry I can't:
Dr: That's fine. Let's just check your glands. And it just started over the weekend did it?
Pt: Well no it's er, sort of Wednesday. It just happened. It's keeping me up most of the night with a tickly cough (Right) but the pain it's in the neck side.
Dr: Yeah, okay. I think what I would suggest is that the likelihood that it's a viral illness. Any, any: You coughing anything up?
Pt: Er yeah. During the night its very mucousy but its mainly clear just around here (Right) I wake up and I can't breath and it's just a tickly cough and (Right) and I blow my nose and generally that's fine.
Dr: What sort of mucous is it? Dark?
Pt: No normally it's just clear.
Dr: Just kind of clearish. Do you have any medical conditions generally?

Pt: No.
Dr: No. Right.
Pt: I'm alright.
Dr: Right. I suspect you've picked up a virus just from maybe being a bit run down exposed to other, other folk and they can give you pretty bad symptoms. There's a few cases that I've seen today actually with similar, similar stories. Irritant cough for a few weeks so em, in the first instance I would suggest that you take um some disprin? (Right). You know, soluble aspirin then gargle with it and then swallow it down so that would give you some pain relief, help the aches and pains a bit which are fairly typical of an infection, a viral infection and it should help the throat as well. You're not asthmatic at all?
Pt: No.
Dr: No. Em so I, I would take that regularly as well. So I would, you know, be taking it three or four times a day.
Pt: Right okay.
Dr: Em and er. You, on top of that, you could also use paracetamol or Lemsips (Right) which contain paracetamol (Right. Yeah). So that's what: so you can use both of them. Em as far as the irritant cough goes you can try a, a linctus preparation (Mhmm). Simple Linctus, which should be available over the counter (Right). That's at the Chemist. Cough suppressant for an irritant cough.
Pt: Right, okay
Dr: Er see how you go with that. Night Nurse, em and I would just give it a few more days. Em, yeah. If you, if you have any close contact with people, if your coughing or breathing over them then you are probably likely to, to pass on (Yeah) I think it: But it would have to be fairly close contact I don't think any;
Pt: A few of them have got heart and lung conditions and whatever and (Yeah) so:
Dr: That's, that's some of the clients who are resident?
Pt: Yeah and I like I travel around a bit to see them
Dr: You travel around to see:
Pt: Yeah.
Dr: Okay.
Pt: Yeah. That's the bit I'm concerned about (doing that).
Dr: Sure, Sure. Yeah, I suppose for the benefit of the, the clients you know, it might be worth having a day or two off until you until you're over the worst of it.
Pt: Right.
Dr: Em, if, if you could be spared that is
Pt: Yeah
Dr: I think, you know and I, I think that:
Pt: I could just go in the office.
Dr: That would be the advice. Just to be to be safe.
Pt: Okay.
Dr: Obviously if there's you know, other circumstances which make that difficult doing the risks are not that great (Right). There is a potential risk, you recognise that yourself. There isn't any evidence that antibiotics would be of benefit at this stage.
Pt: Mhmm. That's right. I just wanted to make sure that I didn't start killing people off
Dr: No. No, no. That's alright?
Pt: That's okay. Okay?
Dr: Yeah. That okay? Do you need some more aspirin?

Pt: Disprin?
Dr: Doesn't have to be disprin.
Pt: I've had this before and I don't think I got on too well with it.
Dr: Right, well what:
Pt: I started taking soluble tablets before:
Dr: Right. Okay well I would just stick with Lemsips then or paracetamol and also to help the aches and pains you could take something like Nurofen, Ibuprofen which is anti-inflammatory (Mhmm) that'll help the pain as well.
Pt: So it's okay to take them on top of the other tablets?
Dr: Yep. No problems whatsoever.
Pt: Right.
Dr: You're okay for the numbers of these you've got here?
Pt: Yep. Yep. I think so.
Dr: Will: You'll not be needing a top up soon?
Pt: Er:
Dr: You got: Your last visit was on the seventh of July (Yeah) and that was two months:
Pt: Yeah, two months. I've just opened another box now so:
Dr: You've just started another box?
Pt: Yeah, I've still got twenty days left. Twenty days of it.
Dr: Okay. That's great with that.
Pt: That's great. Thank you very much.
Dr: All the best.
Pt: Thank you.
Dr: Take care.
Pt: Okay. Bye, bye.
Dr: Come back if its not er:
Pt: Yeah, Ha, ha. Okay thanks.
Dr: Sure.

8. D1JLF

Dr: I haven't seen you since before my holidays I don't think.
Pt: Quite a while.
Dr: Quite a while yeah.
Pt: I have got four things I want to ask you.
Dr: Okay.
Pt: First is I have got a mole on my side that keeps bleeding.
Dr: Okay.
Pt: And mum said I'd better get that checked out em because I have got a lot of moles but this one on my side, I don't know whether because it catches on my clothes,
Dr: Is it on the waistband?
Pt: Yeah.
Dr: Is that the one there? Does it change in colour or anything?
Pt: Yeah it has got darker.
Dr: Right and is it itchy?
Pt: It is a bit.
Dr: It's on your waistband but if it is bleeding and changing colour we should get it checked out by the dermatologist okay?
Pt: I have another one but I have had that since I was born. It hasn't changed colour but it is raised now in the middle.
Dr: Right, right. Well we could get them to look at that as well. Any others?
Pt: Well I have got other moles but none of them have changed just these two.
Dr: Right. Well, what do you understand about the significance of moles to be or changing moles?
Pt: Pass.
Dr: Are you worried about it?
Pt: No.
Dr: Possible consequences.
Pt: I don't really. I'm not really worried particularly about:
Dr: Your health?
Pt: Yeah exactly. I mean it's, I had to go and see the em: To change the subject completely but it is relevant, I had to go and see the Clinical Psychologist.
Dr: Yes.
Pt: Through the court case.
Dr: Right, right.
Pt: And em he wasn't very nice to me and basically he has come back and said that em the fits aren't real (Uhuh) and that there used to be a condition called hysteria or something (Uhuh) and that's what I have.
Dr: Right, right. So what did he:
Pt: That means when I first came back from the army I was extremely angry about it but I mean it doesn't bother me in the slightest now but my mum can't understand that.
Dr: What do you mean?
Pt: She can't understand why I'm not angry about it now.
Dr: Okay. Okay. How long ago did he say that? How long ago was that that you saw him?
Pt: April/May. May, I think it was.

Dr: Right so it was a few months ago since then? Okay and eh have you been seeing any one else?

Pt: I went back to see Dr Robertson in July em just for my follow-up appointment but I haven't actually had a seizure since the 24th April.

Dr: Really.

Pt: Yeah. So he has discharged me completely from Neurology unless. I mean if the fits come back then obviously he is going to see me again but he has discharged me from the Neurology and says he doesn't need to see me now.

Dr: Yeah. Is he quite positive then? Is he quite pleased with himself? His hard line he took with you?

Pt: Mhmm but then it was obviously the right one to take.

Dr: Yeah.

Pt: And I accept that now.

Dr: You accept that now.

Pt: Yeah I accept that now, but I didn't at the time.

Dr: No.

Pt: Which I fully admit but (yeah, yeah) it's very difficult when you are having fits all the time and have someone turn round and say they are not going to treat you (Yeah) the way you want them to treat you, if you know what I mean?

Dr: Sure, but I think you know it was a matter of going along with his view on that so:

Pt: He is the expert so:

Dr: Yeah.

Pt: So he got me to re-apply for my driving licence so:

Dr: Good.

Pt: I am driving in the interim although I don't actually have my driving licence back at the moment. The Medical Officer is going to make a decision but they are letting me drive in the interim at the moment until:

Dr: That is very good.

Pt: I think it is the Medical Branch or something I have to go through so:

Dr: So life is looking up for you?

Pt: Yes definitely.

Dr: You mentioned before that there were 4 things you wanted to talk about.

Pt: The second was em I had an asthma attack and I had to go to Perth Infirmary (Right). On Saturday (Mhmm). It was Carol Smith that I saw (Right) and I mentioned to her that I was coming to see you on Monday anyway. I was wondering if it would be possible to change the Salbutamol inhaler that I'm taking. I'm on the AeroBec at the moment (Yeah). I don't feel that works for me and I have got an Easy Breathe inhaler as well at home that I have been using and don't know if it would be all right to change to the Easy Breathe.

Dr: Now the AeroBec wouldn't be your Salbutamol is it? Is that not the Betamethasone?

Pt: Yeah. They are both the same sort of inhalers that I've got.

Dr: Right. One is your preventor and one is your reliever (Yes, aha) and the Easy Breathe will be your reliever so you will notice an effect from that. The other one you are not going to notice the effect but if you are taking it regularly it is going to prevent exacerbations. So let's just have a look. Now the AeroBec is one of the ones you breathe in. It's an auto-inhaler so:

Pt: Lift the lever.

Dr: And then you suck in so it is the same sort of mechanism as the Easy Breathe? There is none of this pushing down.
Pt: No I have never had one that you push down
Dr: Right, right so okay. How many doses is it that you are taking?
Pt: The Salbutamol?
Dr: The AeroBec.
Pt: The AeroBec I'm taking four in the morning and four at night.
Dr: Right.
Pt: I have upped that because I have been having a bit of a problem because the field in front of us and the field behind us they are both harvesting.
Dr: They'll be harvesting yes so that is bound to. So that's a sensible thing to do I'd say, during the harvest. Em so your usual dose would be two doses twice a day and you have gone up to four twice a day which is quite reasonable. I'm not convinced there would be any you know em mileage in switching the preparation em the AeroBec at the right dose. If you're getting more symptoms we can add something else, but you know the AeroBec seems to be the one you are on.
Pt: Yeah okay.
Dr: It's a reasonable dose and the way that you are taking it, the auto-inhaler is a good:
Pt: Am I okay to get a repeat prescription for that because I will be running out shortly?
Dr: Yeah. Do you want two inhalers at a time? Would that help?
Pt: Yeah please.
Dr: It does work and it is important that you take them every day. They are the ones that keep the symptoms away. Did Doctor Smith give you anything at the weekend? Steroids or anything?
Pt: No. Not this time. They didn't feel that was necessary this time. They gave me 10 mgs of Salbutamol through the nebuliser.
Dr: Right.
Pt: And she told me to, I have been taking Piriton as well for my hay fever and I said I had only been taking one and she said take two.
Dr: Right, at a time?
Pt: Yeah, well no. Two, in a day.
Dr: Two in a day right. You could take at least that you know. You could take maybe up to four or five Piriton tablets a day if you need to. But that might make you a bit drowsy. It won't have any effect on your asthma but it will help the hay fever symptoms. Are you bothered with hay fever through the summer?
Pt: Yeah. This is the first year and I have never been bothered with hay fever before. Both my brother and I have been bothered with it this year but I mean in previous years the field in front of us and the field behind us they have had cattle in but this year they had crops in.
Dr: That is quite common. So you'll need some of your Salbutamol as well then?
Pt: Yeah please.
Dr: How often are you using that?
Pt: I'm not needing to use it at all through the day. It's at night I need to use it and I am using it two or three times through the night.
Dr: Right. I thought we had you down for a nebuliser. Did you have a nebuliser at one point?
Pt: Yeah. Alan has got a nebuliser.

Dr: But it's not that you're needing. It is the EasyBreathe.
Pt: No it's the EasyBreathe.
Dr: What's your peak flow? Are you keeping your peak flows?
Pt: Usually I'll get between five hundred and fifty and six hundred but I am averaging at the moment about four-fifty.
Dr: Okay.
Pt: So it is down a bit.
Dr: Okay so it is down a bit yeah. Should we see how it goes in the next week or two and you keep a record of your peak flows and if it remains down I will need to see you again.
Pt: Right.
Dr: And I would just stay on the four puffs twice a day at the moment.
Pt: Okay.
Dr: Harvest will be here for another week, say in a couple of weeks. Then I would go back down to the two puffs because you need to have some reserve because if you stay on the four puffs all the time that's quite a high dose (Mhmm hmm). But if you need to stay on it for another week or two (Yeah okay) and then you can consider reducing it again.
Pt: I've also applied for em for a job through the Scottish Nursing Guild and they have requested that em they think that I am Hepatitis B immune (Right) and apparently I have to get that from you but I have been, I had to have all that when I started my training in the first place.
Dr: Will we have a record of that then?
Pt: Yes it was done here.
Dr: It was done here. We have got evidence that you had the injections em you have had two Hepatitis B injections. One in: and then a third so you have had the full course but we should have a blood test to say that you were. I think we will probably need to get a blood test from you just to check your immunity status that's all that will be required.
Pt: Okay.
Dr: It's obviously a topical issue in the recent case yes? Okay. Anything else?
Pt: My interview is a week on Wednesday but I go on holiday for a fortnight on the twenty-eighth so I mean I'm still registered as I'm still getting income support at the moment so:
Dr: Oh right okay.
Pt: As far as I know if I go back to work of any sort then I have to have a line from yourself that certifies me as able to return to:
Dr: Able to return to work.
Pt: So would I be able to get a line certifying me as fit to go back to work when I come back from my holiday? Cos it takes two weeks from my interview for them to process my application and say whether or not they are going to:
Dr: Yeah that sounds reasonable.
Pt: Is that okay yeah?
Dr: I mean that will be April that will be just about the beginning of October. That will be: Six months have been fit free and I think that would be reasonable that you return to work. Do you want me to give you: I would suggest you come and see me as soon as your holiday is over.
Pt: Right, okay.

Dr: And I will give you that line. It's just that I need to give you a line saying you need not refrain from work that's all. If you come in I'll do that. Are you going away on holiday?
Pt: Yes I am going to Majorca. It's just me and David
Dr: And is that it all four things?
Pt: Yip. That's it.
Dr: And otherwise all is well?
Pt: Yip. Otherwise I'm, I've applied to finish my training as well
Dr: Good. Good. Your mum and dad must be delighted.
Pt: Oh the difference in them is unbelievable yeah.
Dr: Good.

9. D1JPF

Dr: Have a seat. How are you today?
Pt: Not too bad.
Dr: Good.
Pt: Not too bad.
Dr: What can I do for you today? Is this your first visit back since we met about a month ago?
Pt: Yeah, yeah. Apart from coming in with:
Dr: Yeah, with your wee one.
Pt: Em, well Claire Jones (Yip), she's my Health Visitor and we have discussed anti-depressants a couple times with her and yourself and she just thought it might be a good idea to eh may be come in and speak about that today and see if it is okay to may be start them. I feel, I feel like I would benefit from (Right) maybe being on them (Right). Maybe pick me up a little bit.
Dr: Do you feel any better than you did a month ago?
Pt: I feel slightly better to be honest (Yeah). I tell you some days I feel fine and other days you know I just go back to feeling the same way again (Right, right). I think it just depends whether I have had a good night sleep or not (Right). I think I put a lot of it down to sleep deprivation and (Right) I have been referred to the sleep clinic.
Dr: Yeah, you mentioned that.
Pt: Yeah, so I have got an appointment with a lady there next week and we will see if we get anywhere with that.
Dr: Is sleep a problem with feeds during the night?
Pt: Yeah that is the problem. I am up all the time feeding him during the night.
Dr: How often does he require a feed?
Pt: Well at least five times anyway.
Dr: Five times in a night!
Pt: Yeah.
Dr: So that is every two hours.
Pt: Yeah.
Dr: Really?
Pt: Sometimes it can be twice within an hour or you know.
Dr: Yeah really?
Pt: Last night, as I say some nights you might only get up two or three times but generally he is up about five times which is quite a lot.
Dr: Right. It is exhausting yeah.
Pt: Oh yeah, very, very. It has got to the stage where my partner sleeps in the spare room a lot now because he just can't get any sleep (Yeah, yeah) if he is getting up for an early shift or something he can't:
Dr: Right, he can't afford not to.
Pt: Yeah.
Dr: Oh I see. Em and if you don't, I mean if you try and space out the feeds the wee one creates does he?
Pt: He just wakens up screaming (Right) and the only way I can settle him down is to give him a cosy in (Right) and he will go back to sleep again no problem but is just this wakening up and disturbed sleep all the time. He just won't sleep for any length of time.
Dr: Right so the Health Visitors are going to take that on board?

Pt: Well, yeah. I have to fill in a diary and:
Dr: Sleep diary?
Pt: And see how I get on with that. I think that is mainly why I feel in a mood sometimes.
Dr: Well that is quite understandable.
Pt: I am just so exhausted sometimes.
Dr: Yeah yeah. The first time you came in it would seem that there was a bit more to your mood than just you know you were quite isolated as well.
Pt: Yeah, well, I mean that is a bit of a problem as well.
Dr: Yeah, yeah. Anti-depressants I think eh my feeling after the first interview was anti-depressants will definitely be of benefit to you. Em, but there was the slight reservation you had about the impact on the wee one
Pt: Yeah.
Dr: If you are breast-feeding and we talked a bit about risk benefit and how there is a very small risk of transmission through breast milk. It is pretty negligible and most decisions would be based upon, you know, the need for the anti-depressant. You know, you wouldn't put someone on who doesn't need it and if there is a need for an anti-depressant I suggest that the benefit you would derive from that is greater than the miniscule risk that there is em and I think that would still be, you know, that is the decision that we have to be happy with, that. You know, em, I think the manufacturers always are a bit eh sitting on the fence when it comes to pregnancy and lactation because the studies that they have done haven't involved great numbers and it is often animal studies that they base their results on and em so they tend to err on the side of caution, rather than, you know, say it is okay to take tablets. You often find you know, looking through the lists of drugs for pregnancy or lactation the manufacturers advice is avoid and then in practice you find that the specialists are using these drugs quite commonly without any problems. My experience em over a few years in General Practice has been women who get anti-depressants still continue to breast feed without a problem (Right, yeah) and have no detrimental effects on the wee one so I would say we should give it ago (Yeah). That would be my:
Pt: Yeah, it is reassuring yeah to know that. The only other thing was the weight gain as well. I am really struggling to lose weight and I don't want anything that is going to make me put on any more weight because I couldn't handle that.
Dr: The breast-feeding hasn't helped your weight?
Pt: I just can't stop eating. I did initially. Yeah I, actually I've lost 3 stone but I have come to a point where I,m not losing any more and I'm still quite a bit over weight (Right) and I just can't stop eating now.
Dr: What is your ideal weight or what weight is normal for you?
Pt: I would like to be eleven stone and I'm fourteen stone well thirteen stone ten ounces. I'm fourteen stone.
Dr: Right have you been eleven in the past?
Pt: Yeah, yeah. Ten and a half, eleven but it has been a long time since I have been that right enough. Well before I fell pregnant I was lighter than I am, as well.
Dr: I think you are a lucky lady if you regain your previous weight after pregnancy.
Pt: Oh I know that but I was massive. I still am and I just think, 'Oh God' you know, cos when I was on the pill before that:
Dr: The pill does put weight on.
Pt: Yeah I know that, yeah I know that.
Dr: What are you using for contraception just now?

Pt: Just condoms and sometimes:
Dr: Right. Are you happy with the added risk there is there.
Pt: Yeah.
Dr: There is a risk that you could get pregnant again using condoms only unless you are very careful with them because they are just not as effective a contraceptive as the pill. If they are used with vigilance I don't think you have anything to worry about because you are also breast-feeding, but you can't rely on that. Em if you have a contraceptive failure with the condom you are definitely at risk of pregnancy. So that's something to think about as well whether you want an alternative pill. But unfortunately there aren't a lot that don't give you weight gain (Yeah). The injection or mini pill even more so in terms of weight gain.
Pt: Yeah that is why I didn't take:
Dr: The coil would be another option.
Pt: I don't fancy that.
Dr: You don't fancy that so:
Pt: Not at the moment I just:
Dr: Yeah, yeah. Are you weepy at all going back to your sort of depressive state? You are still a bit labile, emotional. Yeah, okay. Have you talked? Er Claire did a scale on what we call a post natal depression scale and you scored quite highly and so it does suggest that you are going to benefit from:
Pt: Yeah, I think I would benefit. Yeah, I am quite keen to start them now to be honest.
Dr: Okay. Let's talk about your concern for weight gain. I can't guarantee that the anti-depressants aren't going to cause a bit of weight gain. In some people it causes weight loss so that you can go either way. Em, I'm not aware that it is a huge amount of weight gain if there is weight gain and often once you're on the antidepressants and stabilised the side-effects are less noticeable so whether you notice weight gain as a side effect until it is actually there. It is a problem.
Pt: I have got to cut down at meal times.
Dr: Yeah, I mean I think:
Pt: I think it's because I'm bored sometimes in the house.
Dr: Right and that can be a symptom of depression can't it? You know, either loss of appetite or eating for em comfort eating and then you feel bad about yourself afterwards.
Pt: Cos I can't really get motivated to do much in the house and things like say I have not had much sleep that night I just sort of sit there.
Dr: Yeah, it is just sort of a survival thing.
Pt: Yeah.
Dr: So. I think the feeding issue and getting sleep is important too. Because you are not losing sleep because of an illness I think you are losing sleep er it is enforced, it is sort of sleep deprivation.
Pt: Yeah.
Dr: What about during the daytime does he feed as often as that during the day?
Pt: He is not too bad during the day em he always has a mid-morning nap about eleven and tends to want a cosy in about that time and I could really go the rest of the afternoon now. I'm trying to just give him milk in a bottle, formula milk or juice and he will go until about teatime and after that it gets:
Dr: And if you try and give him that overnight he creates does he?
Pt: I just can't get him to be like that during the night at all. I tried to give him a bottle, but I think it's just the cosiness, the comfort of being close to me and:

Dr: Right it is a habit that he has developed which er:
Pt: I tried not to get into that habit but it has been really difficult to avoid it.
Dr: You have obviously talked this through with the Health Visitors. I think that is something you need to discuss a bit more, the sleep pattern. What I suggest we do is put you on a pill, one a day, and it is called Paroxitine. Erm, it will be the first two weeks when it is bedding in you will not notice a significant benefit but you might notice the side-effects significantly.
Pt: Which are?
Dr: It makes you edgy and you just feel anxious (Right)
and that is the one people find most disconcerting because they are expecting something to calm you down and it will calm you down and help your mood once it settles in. It usually takes two weeks to kick in. Again it is a very individual response and some people are not bothered by the first two weeks and other people do notice it, but you do find if you missed pills, the symptoms return, it starts to withdraw quite quickly from your body (Right). So if you come off it you have to come off it gradually. You just can't stop it one day and say I want to stop this today because you will go through a withdrawal reaction and you will get anxious as well and jittery. You know, some people get the idea that these drugs are addictive because of that withdrawal syndrome which isn't the case, but you have to be supervised if you come off it. We usually keep you on it for six months minimum. Sometimes you need more, but that is the sort of time scale we are looking at.
Pt: Okay.
Dr: The other way of looking at it, it takes usually one or two months to get you feeling back to your own, your normal self again and then we would say keep on the pills for minimum of three months after that so I suppose the minimum would be four to five months, but we usually just give six months as a ball park figure and in post-natal depression it certainly has a good record. So we'll get you going right.
Pt: I also have a bit of thrush as well. I wonder if you could: I actually had the Canesten Combi the last time. It's quite good because I couldn't take anything else because I am breast-feeding.
Dr: So do you want some more of that?
Pt: Please, yeah.
Dr: Is there anything else you want to discuss with me today?
Pt: Well I have got an SSP1 form that was sent from my work to try and claim Incapacity Benefit because I'm not getting very much pay and it just says on it that if you can get a statement form the doctor if possible.
Dr: Is there a place to give the statement on the form?
Pt: Let's see. It says just in one of the sections if you could. It's about twenty pages.
Dr: Sometimes on the form they have a space for the doctor's statement.
Pt: No it just says em you have been off for months please send a medical certificate from your doctor with this claim form. Medical certificates are also called sick notes blah, blah, blah.
Dr: Yeah. I could do that. Have you had a sick note lately?
Pt: That's another thing. Sorry. Yeah it runs out on Monday.
Dr: Right.
Pt: You gave me, I think, it was a sixteenth or seventeenth I came the last time and you gave me a month.
Dr: Right. Yeah, okay just get a copy of that done.

Pt: Just copy that and send it to them.
Dr: Yeah, em:
Pt: My boss actually wants to speak to me just to see when I want to go back and I don't know what to tell her.
Dr: I would say once you are on these pills the only issue is going to be, you are going to have to pump milk for the wee one and get child care.
Pt: Yeah, that's in hand.
Dr: If a sleep pattern can be: If you can get that controlled. Cos I mean, to have to work as well, because you are a secretary aren't you? (Yeah) it's not going to be easy to work at the same time. I would say you are looking into the New Year. But not too far into the New Year.
Pt: Yeah. Well I kind of thought that. I thought may be after this and come the middle of January I might be. I have got some holidays and that to use and that could work in and just go back a couple of days.
Dr: Yeah I would say that might be: I think it would be good for you actually to get back to known faces and situations because that would be a support to you as well. Now, I will just get you Canesten Combi. I'd like to see you in a month to see how this prescription is doing.
Pt: Just start taking them now? When do I take them? Morning?
Dr: Morning. Just first thing in the morning.
Pt: Hopefully by Christmas I'll be, I should be okay.
Dr: Yeah. You should be noticing the benefit. This is going to be your second Christmas, no your first Christmas with the week one?
Pt: First Christmas yeah, yeah.
Dr: Have you got family coming over?
Pt: Yeah, there's about eleven people but I'm not doing anything.
Dr: Are they coming to you or:
Pt: Yeah. They are coming to us. It'll be fun.
Dr: Okay.
Pt: Thanks very much.
Dr: Cheers. Bye.
Pt: Bye.

10. D2LMF

Dr: In you come. Did Maggie have a word with you about (Yes aha) the tape being, do you have any problems with the tape being on?
Pt: No. No.
Dr: Is that okay?
Pt: Yeah.
Dr: So what can we do for you?
Pt: Well it's my last acupuncture session and I wonder if you could sort of check me over because I've been on the em pill again, the HRT for about two months.
Dr: Right, okay. It's been a wee while since the last acupuncture, isn't it?
Pt: I know, you were away and then I was away and:
Dr: How do you feel things have been?
Pt: Em what's the pain score again? Ten being the worst?
Dr: Yeah.
Pt: Ahhh, three maybe.
Dr: So is it? Has it maintained it quite well has it?
Pt: Yes, really, really much so. Yes.
Dr: Good. Okay.
Pt: Only really painful if I'm really over, you know if I do a lot of walking.
Dr: And the medication wise at the moment? As far as pain killers are you still taking the:
Pt: The Co-proxamol?
Dr: The Amytryptiline?
Pt: Yes.
Dr: Both? That's the fifty and the twenty-five.
Pt: Yes.
Dr: At night and what about the Diclofenac?
Pt: Diclofenac. Yeah I take that twice a day.
Dr: That's with the stuff with the tummy protector in it?
Pt: Yeah.
Dr: And you take that as well?
Pt: Yes.
Dr: Still think you need all of that? I'm just wondering. I'm just thinking from your point of view.
Pt: Yeah. Em I don't take the Co-proxamol all the time now.
Dr: Fine, right.
Pt: Sometimes I just take one depending what sort of day it's going to be.
Dr: And the others are regular which is the way it should be?
Pt: Yes. Yes.
Dr: That's fine. Okay. Em and the HRT? That's the Premarin. Is that right?
Pt: Premarin. Yes.
Dr: And you've been on that for a wee while?
Pt: I started taking it again about two months ago.
Dr: That's because you stopped it I think. Is that right?
Pt: Yes. I was getting so many, I was so bothered with the hot flushes and everything else I thought well:
Dr: And how have you been since you went back onto it?
Pt: Apart from putting on a bit of weight again which I'm not really pleased cos I put it on when I stopped smoking as well.

Dr: Better to, I mean, I know people don't believe this but it's better having a little bit of extra weight on and not smoking.
Pt: I know.
Dr: But em it doesn't feel that way for folk. Em the Premarin you're on that now. You had a, you had a hysterectomy is that right?
Pt: Yes, that's right.
Dr: Lots of questions today. One other question, am I right in thinking you had treatment for your thyroid?
Pt: Yeah but nothing ever transpired because they said it was kind of borderline.
Dr: And so you've not had anything done about it?
Pt: No.
Dr: And you're not on any treatment at the moment?
Pt: No.
Dr: I'm trying to think when you last had your thyroid checked. Oh there it is. It was actually okay. That was in November. You haven't had it done for a while in fact.
Pt: No.
Dr: November last year.
Pt: Is it that long ago?
Dr: Mhmm. November two thousand. I'm just thinking you need to have that checked again.
Pt: Right.
Dr: I mean no rush.
Pt: No.
Dr: But we need to get you to see the nurse just to have your thyroid test checked again. Okay. Let's take your blood pressure from the point of view of your Premarin. How old are you now?
Pt: Ha. Ha. Fifty-two.
Dr: So you've been up to the breast screening?
Pt: Yes.
Dr: So it's important that you keep going to that with your HRT.
Pt: Aha.
Dr: Em. Do you keep a check on the breasts?
Pt: Yes. No not really. No.
Dr: It is important. I mean the best person to:
Pt: I do occasionally when I think of it. I don't think about it.
Dr: It's just with you being on the HRT there is a slightly increased risk of breast lumps.
Pt: I know.
Dr: And even some people will say breast cancer as well.
Pt: I know.
Dr: The best person that knows your breasts is yourself.
Pt: Yourself.
Dr: And so I mean doctors' are quite happy to examine them if you want them to (Right, Right) but they won't remember what they felt like (Right) last time.
Pt: Right.
Dr: So from the point of view of you knowing if there's a difference or not (Right)
Dr: Then it would make sense that you're the person that keeps a check on them.
Pt: I do do it, when I think about it.
Dr: Yeah I mean it is important I think. That is the one thing

I would say to you is that you should keep an eye on them. Yeah, it's up a bit today.

Pt: Oh is it?

Dr: Yeah, yeah.

Pt: Um I saw Dr Richards when I was in and had it checked regularly for quite a long time and we came to the conclusion that I just probably had blood pressure that's quite high.

Dr: Mhmm, yeah it is, it is up a bit and I think all I would suggest is that when you come back for you blood test in Jan, well I think January would be fine for your thyroid (Mhmm) is that we should em we should get your blood pressure checked by the nurse at the same time em.

Pt: It's tended to be high for quite a while now.

Dr: Yeah. I'm just wondering whether it's been high for a while.

Pt: It has. It's always high.

Dr: Maybe would should think about getting some treatment to try and get it down.

Pt: Right. Right.

Dr: I wouldn't do that today.

Pt: No.

Dr: I would suggest though that we do need to get you back to see the nurse for some blood tests, urine test...

Pt: It is con, constantly high but I've had all the tests. Well
I don't' know if it's the same. Twenty-four hour urine collection (Yeah, Yeah) and all that.

Dr: But this is a sort of bas: sort of again basic thing. Just because you haven't had it done for a wee while.

Pt: But they were constantly high on the high side.

Dr: Can we pop you into one of the rooms next door?

Pt: Yeah.

Dr: So we can pop the needles in and leave you in peace.
And then what I want you to do. Do you want, do you need some more HRT?

Pt: No. I'm alright for that.

Dr: You're okay for it just now. Just that I make sure it's re-authorised for you on the computer. Let me just remind myself. It's a while since I popped needles in, where I put them all.

Pt: Er, two here, one in each and two in each foot.

Dr: So it was between the toes, either side of the ankles?

Pt: Yeah.

Dr: And the hands?

Pt: Yeah.

Dr: Was that right?

Pt: Yeah.

Dr: Yes that's what is says on here but I wanted to check with you. Okay I'm going to put this wee tape thing off just now because obviously we'll be in the other room and then you'll head off.

Pt: Okay.

Dr: Are you still okay for Maggie to speak to you afterwards?

Pt: Yes I am.

11. D2MSF

Dr: So. How are you getting on? Because you had to have another blood test done because you:

Pt: Yes, well, Dr Simpson gave me the report and he said my blood was alright but he thought I should have one two days before I came to you but I got it on Thursday.

Dr: Right they're just getting it for me just now, they're just chasing it up. How are you in yourself?

Pt: Fine except I've got:

Dr: Oh no a cold!

Pt: This funny, no, no its no a cold. It's em it started a while ago but seems to be getting worse and I wondered if it's anything to do with the tablet getting, you know, on to a higher dose.

Dr: When you say a while ago what:

Pt: Well I don't know if it was when I started on this lisinoprin.

Dr: Lisinopril. As long ago as that?

Pt: I don't know. But it's jist. You know, when you're going to sneeze it's usually your nose that tickles well there's a stinging that starts in there and it goes up and then I sneeze maybe three times (Right) and then it goes away Then I seem to have an awful lot of phlegm these days, that I'm having to get up so I wondered if it was anything to do with the tablet Doctor.

Dr: Em:

Pt: It's no a, a, a bad but it's a funny sensation.

Dr: Sure. There's no, there's no doubt that the one you're on the Lisinopril, can give people a cough, can make people cough.

Pt: Aha.

Dr: It can make, give you a cough and it can be quite an irritating, dry, annoying cough that can just be there for no apparent reason. As far as the sort of sneezy feeling goes I haven't:

Pt: It's a funny, a funny. Just a little stinging and then it goes up and my eyes water a wee bit and then a' sneeze maybe three times.

Dr: And does that happen everyday?

Pt: Aye two or three times a day, a few times.

Dr: I haven't heard. I can look it up. I haven't heard of that.
Certainly:

Pt: I was reading the leaflet.

Dr: Right does it say anything in your leaflet?

Pt: Something about you could have a throat or a cough.

Dr: Absolutely. That's the one I know of.

Pt: And er otherwise I mean didnae pay attention to it.

Dr: No but ah, that's just the results. Oh it's still up a bit

Pt: What was it the potassium? Like John?

Dr: Mhmm. It's a bit of a puzzle.

Pt: Well I haven't had any bananas.

Dr: No. No. Since his has been up. That's strange that the two of you have had the same thing but certainly it's up.

Pt: Gosh.

Dr: Ah, what are we going to do with you? Well let's check your blood pressure but (Yes) I wouldn't be happy leaving you with that.

Pt: No. That will be more important than the tickly throat I think.

Dr: Aha, yes. Well, the two things put together though, if it's not suiting you and you think in whatever way it's not suiting you, then we need to think about whether there's something else.

Pt: Yeah.

Dr: It's just with all these things always trying to find a tablet that suits you.

Pt: I've thought I'd better tell you this time cos it seems a bit worse. Remember when I came the last day you asked me if I had a cold?

Dr: Aha.

Pt: Well it had happened through there.

Dr: Happened through there?

Pt: Aha.

Dr: And that was: We just put the dose up there a month ago in November.

Pt: Yes.

Dr: So and do you think it's been worse since the dose went up?

Pt: I think so. Aha. Well you get this into your head:

Dr: It goes into your head sure, okay.

Pt: What's causing it?

Dr: Let's just check what this is doing today and then we'll have a think.

Pt: Oh dear.

Dr: It's still up so I mean if it's still up and you're not feeling right and your blood tests aren't so good (Mhmm) then I think that's telling us, that's telling us something about it. Em cos we've tried you on a few of them haven't we? Em you're still on the Bendrofluazide, which is fine.

Pt: Aha.

Dr: We did have you on the other one. The Filodipine for a wee while but that made your ankles awful puffy didn't it? (Mhmm) So then we changed to:

Pt: Two point five.

Dr: To this Lisinopril. I think that we should change tack completely. I think that we should:

Pt: Take me off.

Dr: Stop it. I think well we've got three reasons to stop it really haven't we?

Pt: Mhmm.

Dr: One, it's not working (uhuh). Two, it may well be making you feel a sort of feeling in your feeling in your nose and throat (Yeah) and we'll find out by stopping it cos that will be better (Aha, yes) and the third thing is, with your potassium being up a wee bit, then it's you know, it just doesn't all fit together (Mhmm). So I would be happy if you just stop it. And what we'll do is we'll choose something completely different.That, that's: There's not one tablet better than another but there's a certain pattern that it's worth going through (Aha) because tablets have other effects that are good for you as well (Yes).That was the reason for choosing the Lisinopril (Aha). But if it can't be used, it can't be used (Mhmm). What I would suggest instead is one that's completely different. It's called Doxacisin. Doesn't really matter what it's called. But (Mhmm) em and again we would start off with the tiniest dose. The good thing about it is it doesn't involve any blood tests. Em no blood test needed, although I would like you to have another blood test to check up this potassium (Yes) has settled itself. But from the point of view of the blood pressure tablet no blood test needed (Mhmm). It would just be a case of keeping an eye on your blood pressure.

Pt: Yes. Will I have a test tomorrow or will I wait. Next week's Christmas so (Yeah) I'm up tomorrow to have my feet done.
Dr: Tomorrow would be a bit too soon.
Pt: Too soon.
Dr: Cos you're (yeah) you need to be off them.
Pt: Yeah that's right.
Dr: For a week or so.
Pt: Aha.
Dr: In saying that it hasn't:
Pt: Will I wait till the New Year then?
Dr: It hasn't, it hasn't gone that much higher than it was last time. It's just the same (aha) and by stopping this I'm sure it will get better (Yes). So my feeling is that waiting till after the new year would be fine.
Pt: Aha. And is the blood pressure just the same?
Dr: It's just the same.
Pt: As it was the last, on the five:
Dr: It's just the same, just the same yeah. It's just the same
Pt: Yeah. No, it was down a wee bit wasn't it?
Dr: Yeah. It's really just the same as it was. It's about it's a hundred and sixty over a hundred. So it's really just the same as it was. Em so I would suggest that you stop it. I would suggest you stay off it for three days, let it out of your system (Aha) before you start the new one I'm going to suggest (Yes) a bit like this one. When you started up I think I warned you that the first time you take it you can sometimes feel a wee bit light-headed?
Pt: Yes.
Dr: Same with this other one. The first time you take it make sure you're taking it and not zooming off somewhere (Yeah). It's usually only the first dose you would ever feel that with (Aha) and after that you're fine with it (Yeah) and I would suggest one a day and back in a month again.
Pt: Mhmm. I'm a problem right enough.
Dr: Oh no. You're not a problem. I think it can be a problem getting blood pressure controlled for certain people
Pt: Aha.
Dr: Medication doesn't always work as well in some people as others.
Pt: No.
Dr: But that's why there's so many on the market.
Pt: Yes.
Dr: It's not because you're the problem, it's just that medication doesn't work so well with some people.
Pt: Aha. Yeah.
Dr: But er I, I still think it's important enough to try and get it under control. I'm not giving up just yet.
Pt: No. Good. So I'll stay off them for three days then?
Dr: Stay off them for three days. I presume you've had it today have you? Have you had your tablet today?
Pt: I've had it today. Aha. I take them in the morning.
Dr: Aha. So this is Monday. Don't take it on Tuesday, don't take it on Wednesday, don't take it on Thursday, start the new one on Friday.
Pt: Friday. Aha.
Dr: And a blood test, the early part of the New Year.

Pt: Yes. Well.
Dr: And back to see me about your blood pressure in about a month from when you start the new tablets.
Pt: New tablet.
Dr: That way I'll also have the result of the blood test back as well.
Pt: That's right. Good. Okay. So John's due to come on the seventh or eight of January to see you. He gets a blood test tomorrow and his Warfarin tomorrow.
Dr: Right. Okay.
Pt: So:
Dr: If you get your blood test.
Pt: Will you be here then do you think?
Dr: Oh aye. Beginning of January. Yes I'll be on first week of January. I'm here.
Pt: So I'll em:
Dr: It's a bit too soon for me to see you but if you come up for your blood tests about them (Aye) they should have, they should have the books made up for that.
Pt: Aha. Aha. I'll have the blood test:
Dr: So will I put that through just now?
Pt: Aha.
Pt: Stop the Lisinopril. This just takes a wee while and put you on. And are you alright for your Bendrofluazide?
Pt: Yes. Er no.
Dr: Or, are you needing:
Pt: No. I'm due to get John's tablets this week but I've got enough of the Bendrofluazide cos we're a bit mixed up now wi' changing the tablets at different times.
Dr: Oh I know. Okay. There we go. That's your prescription for a month of those tablets.
Pt: And I get a blood test at the beginning of the year.
Dr: Blood test the beginning of January just to see if that's okay with your potassium.
Pt: Aha.
Dr: And I'll see you back in about the third week about the third week of January.
Pt: Yes. Now what do I do with this?
Dr: Are you happy still that we recorded it?
Pt: Yes. Yes.
Dr: So what I'd like you to do is go and speak to Maggie who's in Room 2 just for a couple of minutes. She'll just ask you a few questions and that's it.
Pt: Okay.
Dr: Right O'. Thanks very much.

12. D3CBF

Dr: Yeah that's right. Okay.
Pt: It's just about my HRT break
Dr: Oh that's the Climival you're on.
Pt: Yeah Yeah.
Dr: Let me have a look and have you had any problems with that?
Pt: No.
Dr: So everything fine?
Pt: Mhmm.
Dr: How long have you been on it now for?
Pt: Oh God, may be five year.
Dr: Right and how long were you thinking of staying on can I just check?
Pt: Well you talked about this the last time.
Dr: Did that last time did we?
Pt: Yeah. I think I have just may be decided to stay on it just now anyway and I'm no sure we being on the Thyroxin some nights I've got. I dinnae sleep very well and I'm just thinking it's the combination whether it's maybe if I've been lazy and missed a couple missed a tablet or something and it happened before I was on that Climival anyway, have bad nights, sometimes I don't sleep so I think that does help me.
Dr: You think the Climival helps you sleep?
Pt: Yes aye.
Dr: But if you think you miss some Thyroxin that you get:
Pt: Yeah yeah so I'm no actually sure of the combination.
Dr: Can I borrow an arm and check your blood pressure em again - while the machine does it work there. Okay. Em I wouldn't have thought missing you know a single dose of the Thyroxin would have that affect.
Pt: Well may be not for a day, over Christmas it may have been four or five.
Dr: Oh right okay.
Pt: Lazy. They were hidden from the kids like.
Dr: Okay yeah. Now that I could imagine might start to affect you yeah okay. Right if you just rest your hand it works on pressure this so we need to just need to have a nice:
Pt: No I'm quite happy on it like.
Dr: Okay. Oh great I feel that hasn't recorded it. Bear with me a moment. I'll let your arm recover and then I'll just give it one more go.
Pt: Mhmm. Gadgets eh?
Dr: I was just checking something I couldn't remember for some reason what the Climaval was so I was just checking.
Pt: Oh.
Dr: So it is just one of the oestrogen only ones. You have had your hysterectomy?
Pt: Yeah, yeah.
Dr: Yeah. Okay. That is half of the drawbacks of HRT out of the way isn't it?
Pt: True.
Dr: Just pop that down there.
Pt: The only other thing is I have a dry mouth and I am always thirsty and am unable to quench my thirst and this past week I was on a course of tablets from the dentist and my tongue is really coated and furry.
Dr: Okay so are you passing quite a lot of urine as well

Pt: I could do at times yeah. I am drinking through the night as well.
Dr: Okay. Okay. Can I get just to you keep nice and still for any movement disturbs that thing. We should probably think of just checking at some for diabetes if you are doing that, if you are being thirsty and passing urine a lot. Is there any history in the family of it?
Pt: No, no. Just with the constant thirst and my mouth dry
Dr: All right your blood pressure is up a little bit. I would like to repeat it again. I will just get you a bottle and you can hand a sample in at your convenience just to test and make sure that for some reason you are not slipping down that line. I think it would be sensible just as a precaution. Anything else? Do you have much salt in your diet?
Pt: No. I'm not a salty person actually. I mean if it is seasoned when it is cooked that is me basically.
Dr: Okay. I'll check that one more time. Yeah, yeah. Your blood pressure in the past has given the odd high reading, but em:
Pt: Yeah I think the last time was because my father had just died.
Dr: Right. The last time you came to see me it was fine.
Pt: Well I have got a problem with my daughter just now so that would be:
Dr: Right. Okay. I am not going to make any decisions on what your blood pressure does today and you stay on the HRT that is not a problem, but we maybe should monitor it.
Pt: Yeah.
Dr: Yeah.
Dr: What's going on with your daughter? Is that relevant or:
Pt: No they've just split up
Dr: Oh dear.
Pt: It was just well yesterday so.
Dr: Oh no.
Pt: I think that's what it will be. Well Sunday night. Six months married.
Dr: So is she back with you or?
Pt: Yeah. Well we are trying to sort it out but they got married in July and this is what happened doctor. Let me sort it out. It is just trying to get things sorted out. That's the main thing.
Dr: Oh it is disappointing though isn't it?
Pt: Yeah. I'm just thinking of her and what it is doing to her because she is still my daughter. There is nobody involved or nothing it's just, I think they have just got themselves into a rut really (Mhmm).But we'll get there. So that's what that could be because I do get:
Dr: No problem. Why not in that case come back in a couple of weeks with a urine sample just to one of the practice nurses (Right) and just get them to check your urine and your blood pressure (Right). To make sure that it's coming down.
Pt: Right okay. It is not high though is it?
Dr: Well, no it's not. It is at a level that we would normally recommend treatment though, if it stayed there (Yeah, yeah). But as you say so we are just checking that this is just a one off rather than you know. Does that make sense? Okay so come back in a couple of weeks to see one of the practice nurses and em in another six months and continue with the HRT in the meantime.
Pt: Right that's fine okay thanks.
Dr: Bye.
Pt: Bye.

13. D1MFF

Dr: Hello.
Pt: Hello.
Dr: How are you today? Are you agreeable to our little study?
Pt: Yeah. They can listen to what I have to say I suppose. What we have to say. It's not going to be anything too thingmy I don't think.
Dr: Too confrontational?
Pt: I don't think so.
Dr: Apologies for starting a bit late.
Pt: Thank you for that. Well what are we going to do, discuss my foot or the blood pressure first? (Em) Or will we have another appointment for one or the other? No?
Dr: No. We'll maybe just start with your blood pressure.
Pt: Right.
Dr: Just at the end last time we were suggesting you increase your Oxybutin intake to help the urinary frequency.
Pt: Well I've just come off it altogether.
Dr: Have you?
Pt: Because it just wasn't helping in my opinion. It made me have to strain to pass urine when I had to go and I'd rather just carry on at the moment. Right, okay. So now we're discussing the:
Dr: Blood pressure.
Pt: Aye, if you want to take it?
Dr: Will we check the blood pressure today?
Pt: Yes I think so because you put me on that other tablet.
Dr: The Doxicosin.
Pt: Yes, that will be it. Mhmm.
Dr: Okay. And last time you were in a bit of pain and we switched you to Tylex and I wondered whether you were, increased:
Pt: I stopped that as well.
Dr: Is the pain better?
Pt: Because I've been, I was, I asked you if I wanted to discuss my blood pressure or my foot.
Dr: Let's go for your foot then.
Pt: Right. This sounds interesting. You want my foot now!
Dr: Well the blood pressure is (Okay, my foot) not going to go away.
Pt: I was just wondering if you've had a letter about my foot 'cos I've had an injection.
Dr: Yes, I've had a note from Mr Bain, yes.
Pt: Yes.
Dr: And has that helped?
Pt: The injection has helped the heel yes. It definitely has helped the heel but he's then putting me forward for something else. So what has he said there in the letter? (Em) because my ankle was an entirely different pain, apparently not connected.
Dr: Yeah. He said the two things he's mentioned were plantar fasciatis for which he's injected your foot (Mhmm) but he also wanted you to have neurophysiology.

Pt: Yes. That's what it is.
Dr: For nerve conduction studies to exclude any tarsal tunnel syndrome. Now the tarsal tunnel is the channel down the middle of the foot (Mhmm) where: You've heard of the carpal tunnel syndrome?
Pt: Yes, yes, in the wrist.
Dr: It's a similar thing.
Pt: Yes.
Dr: In the small bones in the foot. These are the tarsal bones.
Pt: Aha.
Dr: So it's:
Pt: And that's what's probably causing all the discomfort in the toes and what not then.
Dr: It may be they refer pain.
Pt: Well the other foot's much the same now. It goes 'ohh in the nighttime', they get:
Dr: It's not as though they get:
Pt: They get cold. They feel hot as though they're terribly turning up but they're cold to touch. You know I think I've explained all that before. But anyway, as long as that's what I'm going for. I didn't quite catch him up quite what he said but I understood it was some kind of other test.
Dr: Sure.
Pt: So that's what it is? We'll now await an appointment for that. Good. Good.
Dr: So?
Pt: Good. Good. Now then I wouldn't say the pain in the ankle is quite so bad now cos the other pain has gone you know.
Dr: Aha.
Pt: But at times you feel it giving a thingmy.
Dr: What do you take for that?
Pt: I've gone back on to Paracetamol to oh dear.
Dr: Co-proximol?
Pt: Oh dear. Co-proximol, gone back onto Co-proximol. Because you had this bother of the other ones, of having constipation and having to take something for it and all this (Yeah). Since that severe pain in the heel has gone I can cope with it.
Dr: There is: excuse me. You feel you know where you're going now (Aha) in terms of further investigation?
Pt: Yes. That's, that's:
Dr: There may be something else happening.
Pt: In the end I hope to get some comfort for those feet.
Dr: Mr Bain does tend to you know, operate on the foot if:
Pt: Maybe if necessary. Mhmm. It will maybe come to something that he will say "well take such and such a thing and it will help". Sometimes it builds up and it's really quite uncomfortable. I didn't sleep very well last night for one thing but eventually in fact I took half a Piriton because I couldn't settle and I thought well maybe that will take away that feeling in my feet. And probably it did help, with two Paracetamol, two Co-proximol you know.
Dr: Have you tried going on anything like Viox?
Pt: We did the Viox. Yes we've done the Viox.
Dr: Just trying to remind myself.
Pt: No no, but that was for:

Dr: For pain?
Pt: Well query for pain for arthritis but it isn't really arthritis.
Dr: Right. With little effect?
Pt: Well we still had the pain in the heel at that time. Whether it did do that I don't know.
Dr: It probably wouldn't have much effect on that.
Pt: I think: Can we just sort of leave it then till we sort of oh dear. dear. Do you want to leave the blood pressure just now or:
Dr: If you want to do it, it's up to you.
Pt: Well I'm sorry, after sitting all that time I should have had this off. I apologise.
Dr: Duly noted.
Pt: Oh we're doing it this way today are we?
Dr: Yeah. My machine. 'Cos they take it away and take the blood pressures themselves at home because they're much more representative there.
Pt: Yes, yes. I'm with you, I'm with you.
Dr: You know a one off in the surgery why should you be on treatment for the rest of your life. Got anxious coming to the doctors'. The 'White Coat Effect'.
Pt: Yeah well it disnae worry me the 'White Coat Effect'.
Dr: I once had a GP personally who wore a white coat daily as well. Now that's much improved. It's come down from one eight seven to one six two.
Pt: Well we'd better continue with that other pill.
Dr: Yes. Stay on what you're on just now.
Pt: And see. It means taking three pills.
Dr: Today it's one six two over eighty.
Pt: Eighty? For diastolic?
Dr: Yeah.
Pt: Oh, you'll be pleased about that.
Dr: Yeah.
Pt: And so will the world health organisation. That's all you get nowadays. The world health organisation says you blood pressure should be down to such and such. My two sisters, on about it as well and I've decided you should get us all to put in our different things from different doctors because it's a family problem.
Dr: The blood pressure?
Pt: Yes. So as I say I've got two sisters and a brother all got problems with blood pressure.
Dr: It may well be.
Pt: But they're all on different tablets. Anyway I shall leave you to think about that one.
Dr: Okay. Thank you very much.
Pt: So can I have the, I apologise cos what's happened is I've took some. I got my. oh that's the one that 'Sotalol' (Yeah) and I've only got half the thing back from the chemists. It's all fallen apart. I don't know. Half of the thing didn't come back. So I need the thing redone.
Dr: You're on a hundred and sixty daily are you?
Pt: Of the Sotalol but I don't need it just now. I do need the other new one you've talked about. Aha. I need that.
Dr: Right.
Pt: And I need my 'Zoton' or what's its fancy name? 'Lanzoprozin'. Okay.
Dr: And Co-proximol, you're okay for that?

Pt: You could give me some. I had some not so long ago but I could always save me coming back up for one. And I've been taking the occasional DF118. Now last night I didn't but I thought maybe I should just eventually it helps a bit.
Dr: Have you got enough of those?
Pt: Got about ten left.
Dr: Yeah. Well do you want more of them?
Pt: Right, okay then.
Dr: You don't think you're taking too much:
Pt: Oh no, no, no, no, no. No. It's really just on occasion when they really are getting bad. But the Co-proximol, as I say I've been:
Dr: You discontinued the DF118 for side-effects in the summer time.
Pt: Oh well again that would be the constipation probably. But I can get over that. I can get a Senakot. But the Co-proximol, taking it regularly, say six hourly or eight hourly or whatever, that was just too much and the occasional DF118 doesn't bother me. I've realised that now. Okay? And I've finished the co-codamol anyway and I'll just leave it. I don't want:
Dr: So where are your brothers and sisters? Are they scattered about or?
Pt: My brother is with your surgery and my sisters are with your surgery, but with other doctors I suppose.
Dr: Right. Sixty or thirty tablets, of these?
Pt: Thirty.
Dr: Thirty tablets. I'll put it on repeat as well so if you're running short. So it's not only a family problem, it's a family problem within the surgery we are managing differently?
Pt: Well two, well I think so, I think so. Aha. I can't tell you what my brother's on. My sister's on the Tenuretic stuff I think which I was taken off one time. And my sister in Dundee's on 'Zet'. What do you call it?
Dr: Zeturetic
Pt: Zeturetic
Dr: Which is a different combination again.
Pt: Mhmm.
Dr: The Tenuretic would probably make sense. There's such a wide:
Pt: I know. I know they're all:
Dr: It would very much depend on the personal preferences of the doctor, surgery and so on.
Pt: That's right. But it was quite interesting when we all got:
Dr: It would be more important for them to bring in a record of their blood pressure levels to see whose best controlled. That would be:
Pt: That would be: I think my sister in Dundee's managed to get hers a bit better.
Dr: The powerful one.
Pt: She got the 24 hour machine too.
Dr: Right. Right.
Pt: We were just all discussing it. It is a family thing as I say because no doubt that's what our father packed in with.
Dr: Right.
Pt: When he had his heart attack
Dr: What age was that?
Pt: At fifty odd.
Dr: Right. They may not have had the treatment for it in those days.

Pt: He didn't have anything. No, no. They didn't, that was what it was that was bothering him.
Dr: Did he smoke as well?
Pt: He did smoke.
Dr: We're into the realm of minimising risk factors. It's all down to risk factors according to the:
Pt: Oh yes we know that. We know that. But none of that lot smokes.
Dr: And they're all of an age with yourself?
Pt: Well, slightly below me I think. They are actually:
Dr: They're all about three score and ten?
Pt: Yes. No sixty-ish, sixty odd.
Dr: Right.
Pt: One of them is not even sixty yet.
Dr: Right.
Pt: But you know, there have been blood pressure problems there, throughout time I suppose. But we were all saying "oh the World Health Organisation says", "the doctor says".
Dr: Is anyone else medical besides you or? Has anyone else had medical experience?
Pt: No, no.
Dr: Well the World Health Organisation's what you've got to go by.
Pt: So we gathered when all these conversations came up I can tell you. I said "oh I've tried that one too". Well I hope that doesn't bother the tape too much.
Dr: No, no. You got your form?
Pt: I've got to go and see the lady in room three.
Dr: Thanks a lot, goodbye now.
Pt: Thank you.

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